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Insurance Research Inventory: 1950-1959

FALL, 1959
VOLUME XXVI, No. 3

THE AMERICAN ASSOCIATION OF UNIVERSITY
TEACHERS OF INSURANCE

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Because the distribution of this issue of *The Journal of Insurance* has been delayed for more than two years, this is to remind the reader that this is Volume XXVI, No. 3, issued as of the Fall of 1959. All articles herein contained were submitted for publication during the early months of 1959; none have been revised to take account of the delay in printing.

The final issue of the 1959 series, Vol. XXVI, No. 4, will be distributed within three months. No special notice of this sort will be attached to that issue.

Subscribers should note that the preceding issue of this Volume was not identified correctly on the spine. It was properly marked as "Summer, 1959, Volume XXVI, No. 2" *only* on the outside front cover.

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CONTROL OF ABUSES UNDER CREDIT LIFE AND HEALTH INSURANCE

WILLIAM T. BEADLES

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Close to twenty billion dollars of credit life insurance was in force in the United States at the end of 1957.[1] This amount exceeded the total volume of all life insurance in force in this country at the end of 1914. From less than 1,000 policies in force in 1917, for an unspecified amount of less than half a million, the volume of credit life insurance in force grew to one hundred million in 1935, one billion in 1947, ten billion in 1948, and over twenty billion in 1958.

Credit life insurance is a form of cover purchased to liquidate unpaid balances of loans in the event of death of the insured debtor. Much of this insurance has been purchased voluntarily by debtors; however, in many instances the creditor has compelled the debtor to acquire this insurance as a condition of the loan, as he wants to assure repayment in event of the debtor's death. In fact, the debtor often has had no knowledge of the existence of the insurance, even though the creditor has charged him for it.

As the credit life insurance business grew, abuses developed which eventually attracted the attention of insurance regulatory authorities. The National Association of Insurance Commissioners (hereafter referred to as N.A.I.C.) recently became interested in these problems and has devoted considerable attention to the subject. Out of the deliberations and studies of this organization has emerged the N.A.I.C. Model Credit Life and Credit Accident and Health Regulation Bill, the latest version of which was approved in the December, 1958, N.A.I.C. meetings. An analysis and evaluation of this Bill constitute the remainder of this article.

Abuses and the Model Bill

No attempt will be made to examine in detail the abuses which have been too prevalent in the past. Earlier studies have focussed sufficient attention on this area. The abuses reviewed in this section are presented merely to emphasize the significance of certain provisions of the Model Bill.

Excess Amounts of Insurance

On March 26, 1948, the Missouri Superintendent of Insurance issued an order placing restrictions on the sale of credit life and health insurance. He stated that, "Numerous complaints have come to the Division of Insurance that lending agencies . . . require as a condition to making (personal loans) that the borrower purchase life insurance and accident and health insurance in amounts greatly in excess of the loan. . . ."

A 1952 memorandum issued by the Attorney General of the State of New Mexico showed that, for seven lenders whose operations had been scrutinized, the average increase in loan balances attributable to credit insurance premiums was

Editor's note: This article was written in the Spring of 1959.

[1] Life Insurance Fact Book (New York: Institute of Life Insurance, 1958) p. 10.

59 per cent. The range among these lenders was 16 to 149 per cent. If the average amount of a loan balance be increased by 59 per cent by reason of the credit life insurance premiums, it is evident that the insurance must be written for an amount larger than the original loan. Such insurance obviously is not being used for the sole purpose of covering the unpaid balance in event of the borrower's premature death.

One further illustration of the excessive insurance abuse was described by Insurance Commissioner J. Edwin Larson of the State of Florida.[2] In referring to a 1954 report of a sub-committee of the N.A.I.C., he cited an example of a $50 loan for a three-month period, on which the borrower was charged premiums for $100 of life insurance for twelve months and $150 of accident and health insurance for a period of four months!

The Model Bill seeks to prevent the above abuse by stating in Section 4a, "The amount of credit life insurance shall not exceed the initial indebtedness." Section 4b, provides that "The amount of periodic indemnity payable by credit accident and health insurance . . . shall not exceed the aggregate of the periodic scheduled unpaid installments of indebtedness and shall not exceed the original indebtedness divided by the number of periodic installments."[3]

In addition to providing that the amount of credit life insurance may not exceed the initial indebtedness, special provision is made for the typical situation where repayment is to be made in substantially equal installments. Here the Bill states that the amount of life insurance shall at no time exceed the scheduled amount of indebtedness in the case of individual policies and shall at no time exceed the amount of the unpaid indebtedness if group insurance is being used.

All that appears necessary in order to abolish completely the problem of excess insurance is for the state to enact the Model Bill and to see that its provisions are enforced.

Insurance for Excessive Period of Time

The next abuse which the Model Bill seeks to eliminate is that which compels the debtor to purchase insurance to extend substantially past the scheduled maturity date of his indebtedness. A 1945 report of a Wisconsin legislative investigating committee told of a lender who charged the borrowers for the insurance ranging from 18 to 24 months but wrote the individual policies for only 12 months. If the loan was paid in full before the termination of the 12 month period, no refund was given to the borrower.[4] The example referred to earlier of a life insurance policy issued for one year to cover a loan which was to run for three months, furnishes another illustration of this type of abuse.

A solution to this problem is found in Section 5 of the Model Bill: "The term of such insurance shall not extend more than fifteen days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor."

Pyramiding of Coverage

Section 5 of the Model Bill deals with another widespread abuse. This section simply states that if the debt is discharged due to renewal or refinancing prior to the scheduled maturity date ". . . the insurance in force shall be terminated before any new insurance may be issued in

[2] The occasion was an address delivered at the Third Annual Consumer Credit Conference held in St. Louis, Missouri in 1956.

[3] The accident and health provisions of the Model Bill will be referred to only to the extent necessary to elaborate the basic restrictions provided in the Bill. No attempt will be made to evaluate these provisions.

[4] Final Report of Joint Interim Committee on Interest Rates and Loan Charges (1945), p. 20.

connection with the renewed or refinanced indebtedness." This provision is designed to prevent the so-called pyramiding of coverage. The problem arises from the fact that many installment debts do not run to maturity but instead are renewed at periodic and frequent intervals.

Commissioner Larson stated that the N.A.I.C. sub-committee found it was customary in some areas for the creditor to compel the purchase of new insurance with each renewal of a loan. At the same time, the coverage which had been written in connection with the prior loan was not cancelled. This meant that borrowers frequently were found to have several policies in force at one time. If each one was for either the original or the unpaid balance of the loan, the total amount of insurance in force would have been substantially more than the unpaid balance even though no excess insurance had ever been issued in connection with any prior loan transaction.

Failure to Deliver Evidence of Insurance

Section 6a of the Model Bill provides that "All credit life insurance and credit accident and health insurance sold shall be evidenced by an individual policy, or . . . by a certificate of insurance, which . . . shall be delivered to the debtor." This provides further evidence that the people who drafted the Model Bill knew about the abuses which they were trying to prevent. A November 12, 1952 news release of the Denver Area Better Business Bureau stated that the majority of those who had complained to it did not even know that they were paying for insurance until they received their payment schedule cards through the mail. A 1951 report by the chairman of the San Antonio Junior Bar Anti-Usury Committee stated, "The borrower in most cases had no knowledge of existing insurance and consequently few claims were ever made thereon."[5]

Commissioner Taft of Wyoming, was reported as saying in March, 1954, "a borrower found it necessary to borrow money from three different lenders, each of whom sold him a life insurance policy and an accident and health policy . . . my investigation showed that they did not deliver the policies to the borrower, who claims that he was not even advised he had purchased insurance policies. . . . It appears that failure to deliver policies to borrowers is due to the fact that the money lender has a financial interest in contingent commissions, which he receives, providing no claims are filed against the policy." He is further quoted as saying, "It is obvious that if a borrower doesn't know he has an insurance policy, he will file no claims against it."[6]

Section 6b lists the information which is required on each policy or certificate. In addition to the full identification of the insurer, each one must show the premium charged to the debtor and both the amount and the term of the insurance coverage. This section also provides that if the insurance becomes payable, benefits equal to the amount of the unpaid indebtedness shall be paid to the creditor and any excess proceeds shall be payable to a beneficiary, other than the creditor, who is named by the debtor, or to the estate of the debtor.

Section 6b states that if it is not possible to deliver the policy or certificate to the debtor at the time the indebtedness is incurred, he shall be given at that time a copy of the application for such policy or a notice of proposed insurance, signed by the debtor. This must contain essentially the same information required in the policy or certificate. In any case, the policy or certificate must be delivered to

[5] Goode, *Harassing the Loan Shark* (1951) 14 Texas Bar Journal 112.

[6] Quoted in *The Wyoming Eagle*, Cheyenne, Wyoming, March 27, 1954.

the debtor within 30 days of the date upon which the indebtedness is incurred.

Failure to Refund Premiums

Refunds must be made to any debtor who has paid a premium and has his insurance terminated prior to the scheduled maturity date of indebtedness. The Model Bill thus provides that if the debt is paid ahead of time, the borrower is entitled to a proper refund of a portion of the premium which he has been charged. The formula to be used in computing refunds must be approved by the Commissioner. He also is given the power to prescribe the minimum amount below which no refund would have to be made.

The importance of the refund requirement is illustrated by the following quotations from the Downey Report of 1957.[7] "One of the largest finance companies admitted that, as a matter of policy, it did not make any refunds on the cancellation of any policies." The same Report cites the situation of one borrower who was charged $36.58 for a three year credit life policy. When he paid his loan balance in full at the end of the first six months, he was told that no refund could be made.

Non-Payment of Claims

Section 10, dealing with claims, is aimed directly at another abuse which apparently has been rather widespread. Paragraph c of this Section provides: "No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims. . . ."

Commissioner Larson, in the speech referred to above, stated that the N.A.I.C. sub-commmittee encountered many abuses concerned with the non-payment of claims. He said, "In other instances, even though evidence of insurance had been furnished, the debtor filed his claim with the creditor, and settlement of the claim was handled by the creditor. Under such circumstances, if the creditor's compensation was in any way related to loss experience, there existed an obvious temptation to deny as many claims as possible." Evidence exists that there have been agency contracts in which the agent's compensation was 80 per cent of the premium less the amount of claims allowed.[8] The control imposed in the Bill should result in practically all legitimate claims being paid.

Section 10, does provide that the group policyholder (probably the creditor) ". . . may, by arrangement with the group insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer."

Coercion

Another abuse encountered was that of coercion. There have been many cases where debtors have been required to take the insurance and have been given no opportunity to select the agent or company through which such coverage should be provided. A 1954 Georgia case furnished specific evidence of this coercion. The court stated ". . . that the lender, who was agent for an insurance company, required that the insurance be taken out through himself as such agent and with the company desired by him . . . that it was impossible for prospective borrowers to obtain a loan from the defendant without taking out both life insurance and health and accident insurance in accordance with his terms. . . ."[9]

[7] *Report on Insurance Charges in Consumer Credit Transactions* submitted by F. Roger Downey, Assistant to the Superintendent, to Leffert Holz, Superintendent of Insurance of the State of New York, January 24, 1957, p. 23.

[8] "Illegal Lending in Missouri," *Missouri Law Review* (June, 1951), p. 13.

[9] Tribble v. State (Ga. App. 1954), 80 S.E. 2d 711.

There should be no question as to whether a creditor is entitled to require whatever security he thinks is necessary to protect his interests. Within the limits set by the state small loan law, there is no reason to criticize any lender who insists upon the debtor furnishing proper and adequate insurance protection. The abuse comes when the debtor, who may already have sufficient insurance, is required to take out additional insurance against his will. Abuse also appears when the creditor compels the debtor to purchase insurance through the creditor.

The Model Bill seeks to meet this problem by providing in Section 11, "When credit life insurance or credit accident and health insurance is required as additional security for any indebtedness, the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within the state."

Rate Abuses

It has been shown that enforcement of the Model Bill would prevent the debtor from being coerced into purchasing unnecessary insurance, from being charged for insurance without receiving sufficient evidence of the existence of that insurance, and from the other abuses which have grown out of the writing of credit life insurance. The sole abuse not controlled is that of the imposition of excessive rates on the debtor.

Reverse Competition—The Motivation for Excessive Rates

The problem of rate regulation, relative to credit life and credit accident and health insurance, is particularly acute because of the condition of reverse competition. A 1957 study by the N.A.I.C. described this condition in the following terms: "Competition in the sale of insurance usually results in better service and reduction in costs to the insuring public. However, in the field of insurance in consumer credit a new factor has been developed that may be termed 'reverse competition.' Some insurers have offered creditors successively higher rates that would result in the return of increased commissions or experience dividends to the agent, creditor, or its affiliates. As a result, competition is guided not by the usual rule of the lowest possible rate to the insured borrower, but rather on the basis of increased financial returns to the creditor. This higher rate of charge is paid by the borrower whose inferior bargaining position is generally recognized to be wholly inadequate to remedy this procedure of 'reverse competition.' "[10]

The Model Bill and Rate Regulation

The Model Bill provides that the commissioner shall have the power to disapprove any forms if the benefits provided are not reasonable in relation to the premium charge. As a basic standard, no one can quarrel with this. As a statutory provision, however, it seems to be far from adequate. Immediately questions are raised. "When is a rate reasonable?" "What are reasonable benefits for a given rate?" "How is the commissioner to determine the reasonableness of rates"? The law establishes no benchmarks for the guidance of commissioners. Under the terms of the Bill, there appear to be only two courses open to regulatory authorities in protecting the public against excessive rates. First, they may disapprove any proposed rate. However, this must be done within 30 days of the filing. If the commis-

[10] *Insurance Problems in Connection with Installment Sales and Loans*, Sub-Committee Report, December 1957, 11-19. Also in 1958 Proceedings of the N.A.I.C., Vol. I, p. 121.

sioner does not then have adequate data on which to base a disapproval, the rate becomes effective. It continues in force until the commissioner is able to gather sufficient data on which to provide for withdrawal of approval under the procedures set up in the Model Bill. It is reasonable to assume that, at the very minimum, it will take the commissioner several months to accumulate sufficient data on which to base his request for withdrawal of approval. During this time, the rates he considers exorbitant have been in full effect.

If the commissioner is successful in withdrawing approval, there is nothing to prevent the same insurer from filing a new form, with a rearrangement of benefits or the addition of some minor ones, with the same rates which were already considered to be too high. The merry-go-round revolves again. The commissioner must take time to accumulate evidence, which probably would have to be a long enough period to establish loss ratios. If he can again withdraw approval, the same procedure can be repeated. In the meantime the public goes on paying exorbitant rates.

The second approach would be for the commissioner to establish a rate structure which represents the maximum permissible for these policies. This could be done through departmental regulations, similar to action already taken in the states of New York and New Jersey. At the time this is being written, however, the New York Department is under an injunction to prevent its Regulations from being enforced; and the New Jersey Department has indicated that it may be exposed to similar treatment.

Alternative Controls over Rate Abuses

Several alternative approaches to solving the problem of rate abuses have been suggested. One proposed solution is to give the commissioner of insurance the power to establish rates. This approach in the Model Bill would offer the public more effective protection. Whereas the present version forces the commissioner to prove that benefits are unreasonable in relation to the proposed premium, this alternative would place the burden of proof upon companies to demonstrate that the rates established by the commissioner are not reasonable. The consumer would have much greater protection from excessive charges under this procedure, as the rates established by the commissioner would prevail until they were proved to have been unreasonable. There would no longer be the possibility of the insurer's proposed rates being used while the commissioner was trying to gather sufficient data to show their inappropriateness.

Why does the Model Bill not include the more realistic[11] approach to the rate question proposed above? Although one cannot be sure of the answer, it would seem reasonable to suggest that the opposition of the insurance industry has been a major factor. The industry has never been subjected to rate regulation as just described, and it is almost unanimously opposed to such an approach. This stand is based upon the fact that free competition between companies works in the public interest as each insurer tries to provide the best possible benefits for the least cost. This argument is presented in spite of the condition of reverse competition which prevails in the field of credit life insurance. The industry apparently fears that such an approach to rate regulation would be a "foot in the door" to more widespread regulation of all life and health insurance rating.

Another approach would be to require the creditor to pass on to his debtors any dividends or retroactive rate refunds in excess of his cost of providing his coverage. Since any lending agency has a con-

[11] "Realistic" from an economic point of view if not from that of legislative politics.

stant turnover of debtors, it has been suggested that his can be done by using the available amount to reduce the rates charged future debtors.

Regulation along the lines suggested in the second approach would be difficult, if not impossible, to administer. It would be necessary to agree upon each creditor's cost of providing coverage and have the state insurance department see to it that he is offering the appropriate refunds or rate reductions. More important, since the higher-cost individual policies are usually non-participating, this proposal would affect only the group policies. Also, if the creditor is denied the benefit of these dividends, the low-cost group insurance will become even less attractive to him. The net result probably would be a higher cost to borrowers as fewer creditors would be interested in using group insurance.

A third proposal is to limit the amount of compensation given lenders for marketing this coverage. This approach was sponsored by the American Life Convention, the Life Insurance Association of America, and the Consumer Credit Insurance Association. One such proposal of the latter Association set this limit at 40 cents per annum per $100 of credit life insurance and 60 cents per $100 for accident and health insurance, with a 14-day elimination period on an indebtedness of one year's duration.

The compensation schedule indicated is excessive. The customary charge for group life insurance has been 40 to 50 cents per $100. Obviously, a company charging such rates could not make 40 cents available to the lending agency. Unless such a group company raised its rates to a point where it could produce the 40 cents return to a creditor it would write little, if any, business. This leads to the conclusion that a proposal to limit payments to the lender will increase the cost of this insurance to the public because individual policies become more attractive to the lender. Eventually most, if not all, of the low cost group insurance would be replaced by individual policies or by group insurance at an increased cost.

Still another proposal is to place a limitation on the charge which can be made to the debtor by the creditor. The subcommittee staff of the N.A.I.C. suggested such a limit. This fourth approach seems to be a desirable approach because by placing a limit on the charges to debtors, a limit on the creditors' compensation follows automatically. However, this staff proposal indicates that the charge to the debtor shall not exceed the premium charged by the insurer. This of course, standing by itself, does not solve the problem as it only encourages the continuance of the "competition in reverse" which the proposal is designed to control. The only sure way to prevent this is to have a maximum charge to the debtor which is fixed without regard to the form of policy used or the premium charged by the insurer.

It may be concluded that non-profit regulation does not attack the basic problem, in fact it will aggravate it; rate regulation is unpalatable to the insurance industry; compensation regulation does not solve the problem of competition in reverse; a maximum charge to the borrower if fixed at a reasonable level, certainly would do the job.

Rate Differentials Between Group and Individual Plans

Much of the problem with respect to rates stems from the different situations existing with respect to group versus individual coverages. Statistics show that individual policies (those written largely by the so-called specialty companies) always carry a substantially higher premium and show a much lower loss ratio than do group policies. This is in spite of the fact that there should not be any significant difference in mortality as between group

and individual credit life insurance.[12] Hence, the premium charge for individual credit life should not differ essentially from that of group.[13]

A second factor contributing to the higher rates of individual policies is that commissions paid are much higher than for group policies. This is in spite of the fact that distribution costs for both types of coverages are about equal. In both areas the sales effort is at the company level. There is none of the programming service and other special features which differentiate the sale of individual life insurance from group life insurance. The insurance company simply makes an arrangement with the creditor whereby his debtors will be insured. Due to the captive situation of the borrower at the time of the transaction, the creditor's sales effort would seem to be negligible and could not justify the high commissions which have been reported.

In writing to all state associations of the National Association of Insurance Agents, the Executive Secretary and General Counsel of the Association stated in March, 1953 that the cost of individual credit life insurance policies varied from $1.00 to $2.00 per annum for each $100 of initial amount of loan, with the commission to the lender ranging from an admitted 40 per cent to an unadmitted 85 per cent of the premium. He stated that group life "which serves the same purpose" is sold at a rate varying from 49 cents per year per $100 of initial amount to 35 cents and that no commission is paid to the lender.

While the above source may be prejudiced, the statements are generally verifiable. When individual policies are used, the creditor is in effect, if not legally, an agent of the insurer. He sells his policy to his "captive client" and collects his commission. Since borrowers do not typically shop around, the creditor has no financial incentive to represent an insurer whose rates are low. The higher the rate charged for the insurance, the larger the commission which can be paid to the lender.[14] On the other hand, when group insurance is used, the creditor contracts with the insurer for insurance on his borrowers. He then typically charges the borrower the same amount which he pays. This does not mean that he is completely altruistic, however; for he may receive dividends and experience credits. In this situation the creditor is not an agent for the insurer; instead he buys insurance and collects a proportionate part of the premium charge from his debtor.

The 1957 Official N.A.I.C. Report on 1955 and 1956 operations showed that the group companies averaged commissions of 7.6 per cent compared with 39.9 for the individual companies. These averages, however, are misleading as 52.2 per cent of the companies selling individual insurance paid commissions ranging from 50 to 70 per cent, while 70.4 per cent of the group companies paid less than 20 per cent. Some dividends and retrospective credits were paid on the group business; but 52.5 per cent of the companies paid none of these items, while 11.1 per cent paid less than 5 per cent in this manner.[15]

A review of the above figures provides convincing evidence that the real role for the individual policies is that of compelling the borrower to pay more for the same benefit in order that extra profits might be available for lenders and insurers.

The manager of the Fire and Casualty Department of Alfred M. Best Company,

[12] Based upon a N.A.I.C. report in 1957 covering the 1955 and 1956 operations of companies writing 96 per cent of the credit life insurance in force in December, 1956.

[13] *Ibid.*, 11-21. Also in 1958 Proceedings of the N.A.I.C., Vol. I, p. 121.

[14] Also, the greater will be the amount of the total loan on which the creditor will earn interest.

[15] *Ibid.*, II, 10-12. Also in. 1958 Proceedings of the N.A.I.C., Vol. I, pp. 116-117.

writing in October, 1951, stated in referring to one company which wrote only credit insurance, ". . . The amount of losses paid in comparison with net writings is unusually small, while expenses are exceedingly high . . . we understand the 1950 annual statement showed commissions incurred to be around 90 per cent of the net premiums written."

In the famous Tribble case, referred to earlier, the Georgia Court of Appeals indicated that the lender received 75 per cent of all premiums collected. The insurer set aside another 10 per cent of the premiums in the name of the lender for payment of claims, so his commission amounted to 85 per cent. Although policies were issued in the names of the borrowers, they were never delivered to the borrowers. One of Tribble's transactions was a three month loan for $50, repayable in six equal semi-monthly installments. The charge was 75 cents for interest, 25 cents policy writing fee, and $17.04 for insurance.

The Tribble illustration lends support to the statement of the Attorney General of Kansas in March, 1954, that "Some loan companies make more money from the commissions on the sale of insurance than from the interest on the loans to the borrowers."[16] He related a situation where a man had to pay $98.58 to the lender for insurance premiums on loans totaling $154.51. The interest charge was $17.99, making a loan cost of $116.57 for the $154.51 loan. This borrower received no insurance policy.

In September, 1952, the State Board of Insurance Commissioners of Texas held a public hearing on credit insurance. An exhibit which was prepared from reports made by each insurer selling credit insurance in Texas from January 1, 1951, to December 1, 1951, showed, for all lines, total premiums collected of $10,695,712. Total commissions paid were $7,491,965. Claims paid were $753,744, or 7.05 per cent of collected premiums. For the 26 reporting companies, the ratio of claims paid varied from zero to 29.4. Only four companies showed claims above 20 per cent. Only eight were above 10 per cent. Fifteen were below 5 per cent.[17]

The large group-writing companies have consistently urged a form of rate regulation which would tend to put an end to the reverse competition that exists in the field.[18] Granted that they were selfishly seeking to protect their own interests, it seems reasonable to characterize their position as one of enlightened selfishness.

The author agrees with a conclusion stated in the New York State Banking Department Study of 1957, "An Analysis of the Licensed Lender Industry," that ". . . in principle no profits whatsoever are justified."[19] This refers to profits from the sale of the insurance. The lender already has two sources of "hidden profit" even if he receives no commission. Bad debt losses due to the death of the borrower,

[16] Quoted in *The Topeka Daily Capital*, Topeka, Kansas, March 2, 1954.

[17] *Public Hearing on Credit Insurance Before State Board of Insurance Commissioners*, September 24, 1952, Exhibit D, p. 9.

[18] Reference has been made earlier to the exorbitant commissions paid in connection with the sale of the individual policies. Closely related are loss ratios. The N.A.I.C. 1957 Report showed that 39.5 per cent of the group companies had loss ratios of 50 per cent or more as compared with an average loss ratio of only 6.5 per cent for those writing individual decreasing insurance. Over half of the latter group had loss ratios under 20 per cent and almost one-third showed less than 10 per cent. (pp. II, 7)

The Downey Report of 1957 stated that the nationwide experience of the New York admitted companies for 1955 showed a 25.7 per cent loss ratio on individual policies and a 54.8 per cent ratio for group policies. (pp. 14, 17)

[19] This Study stated further, "The major question is how to protect a borrower from being charged an 'excessive' rate for insurance coverage. In the determination of a proper rate, the major guiding principle should be that borrowers obtain maximum insurance protection at the lowest possible cost and that the sale of credit life insurance should *not* result in profit to the

and the expenses incurred in trying to collect these amounts, are eliminated. Secondly, the premium for the insurance is added to the loan, thus increasing the amount on which interest is charged and earned. The New York study estimated that the amount of extra borrowing (on which additional interest would have been earned) would have been $1,960,000 in 1957 in New York State alone, if a fifty cent rate had been in effect.

On the other hand, in trying to estimate the cost to the lender of handling the insurance, the same New York Study concluded that the 22 cents cost per $100 of loans outstanding claimed by one large loan company was "overstated by more than 70 per cent." Eight cents per $100 was assumed to be an adequate cost of handling the insurance. This latter figure was said to be 70 per cent higher than the cost figures submitted by another large lender. At an eight cent rate, it would have cost creditors $190,000 to administer credit life insurance in New York State in 1957.[20]

Similarly, it was estimated that licensed lenders in New York State charged off approximately $370,000 in 1957 as uncollectable because of the death of the borrower. For the moment let us ignore the extra expenses incurred in trying to collect this amount and assume that the law would have permitted these lenders to sell credit life insurance. It would seem that the lenders could have sold the insurance at cost, whatever that cost was, and in addition could have absorbed the estimated $190,000 of extra handling expense in order to collect what otherwise would have been $370,000 of bad debt losses.[21]

Conclusion

The Commissioners' Model Bill proceeds effectively and directly to eliminate all of the major abuses except that of excessive rates. With regard to rates, the roundabout and vague approach to the problem leaves just about everything to be desired. With no suitable bench marks for the guidance of the commissioner, rate regulation under this Bill becomes little more than a pious hope.

Commissioner Sullivan of Kansas, writing to "All Commissioners" on March 1, 1954, stated that he had ". . . regretfully reached the conclusion that should (the then existing Rules and Regulations) be adopted in Kansas, the abuses which presently exist would not be corrected." The Rules to which the Commissioner referred are essentially the same as the present Model Bill. He pointed out that ". . . credit insurance represents an opportunity for the (dishonest and unscrupulous) lender or seller of goods to increase his profits through unduly high commissions in relationship to effort expended."

Although many meetings have been held and many different proposals made since 1954, the present Model Bill still leaves uncorrected Mr. Sullivan's objection.

The failure of the N.A.I.C. to control rate abuses poses the problem of the "threat" of Federal regulation. By failing to face up to this rate problem, the N.A.I.C. could be providing effective ammunition to those who see Federal regulation as the final answer. Commissioner Navarre's remarks at the November 14, 1957 meeting of the Committee

lender. . . . *Representatives of the licensed lender industry have expressed to the banking department their complete agreement, in principle, with the view that there should be no profit in the sale of credit life insurance to their borrowers.*" (p. 80) One can only wonder at the significance of this "agreement" and its definition of profits.

[20] Pp. 82-89. Remember that this Study is trying to show what the financial result would have been if the licensed lenders had been permitted to, and had sold credit life insurance under the assumed conditions.

[21] In addition, as noted earlier, the creditors would have earned interest on an extra $1,960,000 of loans, this amount representing a reasonable premium charge.

on Insurance Covering All Installment Sales and Loans, are pertinent. He affirmed such a threat unless the states took reasonable action to correct the abuses in the credit life and credit accident and health insurance field.[22]

Commissioner Navarre probably had in mind one of two reports of the Subcommittee on Antitrust and Monopoly Legislation of the Committee on the Judiciary of the United States Senate. One of these reports was made in 1955, following investigation of the tie-in sale of credit insurance in connection with small loans and other financial transactions. The subcommittee stated that one of the questions to which it sought an answer was "Should Public Law 15 . . . be amended or repealed?" The fact that this question was even raised is significant. The concluding paragraph of this Report stated, "This subcommittee will not allow itself to be blinded by subterfuge. Neither will it turn a deaf ear to those of our citizenry oppressed by the coercive practices related in this report . . . While these abuses here related continue, this subcommittee will not forever accept 'attempts' at regulation as a substitute for regulation of the business of insurance by the States. The patience of the Federal Government with those who would abuse the good name of insurance some day may come to an end."[23]

On March 5, 1959, another report of the same subcommittee identified the above study as being "the first attempt by the Congress to determine whether the dual system of Federal-State regulation of insurance has been successful and to appraise the effectiveness of State laws and regulations." This new report refers to the ". . . danger of a possible no man's land where the public interest is not protected by either State or Federal law." The report continues ". . . (It was) mandatory for the Congress to proceed with a thorough-going study in order to determine whether the McCarran Act had achieved its purpose of securing competition in the insurance industry. . . ."[24]

The possibility of Federal regulation is a side issue in this study. It is mentioned only because of the failure of the Model Bill to come to grips with the rate problem. Because of this basic defect in the Bill, it is the considered opinion of this writer that it does not deserve the adjective "Model."

[22] 1958 Proceedings of the N.A.I.C., Vol. I, p. 146.

[23] *The Tie-In Sale of Credit Insurance in Connection with Small Loans and Other Transactions*, p. 14.

[24] *Activities of the Sub-committee in Antitrust and Monopoly, 1958*, p. 18.

A COMPARISON OF MORTALITY RATES OF INSURED LIVES WITH THOSE OF THE GENERAL POPULATION

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It has long been recognized that mortality rates for insured groups differ from those applicable to the whole population. This difference is the result of certain selection processes on the part of both insurer and insured. The insurer's selection processes are well known and thoroughly described in the insurance literature. They usually take the form of underwriting rules which indicate the conditions under which an applicant should be accepted or rejected.

Selection by the insured similarly is an important factor in determining the level of mortality. While knowledge of insured selection is less extensive than that concerning insurer selection, it is possible to cite three important factors which influence the insured in this area. These are: (1) physical condition; (2) economic status; and (3) psychological disposition. Physical condition is important since a sense of physical well-being may direct an individual away from insurance to annuities, and conversely. Economic status influences the amount of insurance an individual can afford. A person's psychological disposition will indicate whether or not he is emotionally disposed toward insurance. It could be argued that an individual's resistance to insurance is directly related to his ability to bear uncertainty. These factors, and others related to them, will have their ultimate effect in the mortality experience among insured lives.

There is, however, one important difference between insurer selection and selection by the insured. The selection procedures of insurers are always designed to affect the rate of mortality so as to reduce the cost of the contract, whether it be insurance or an annuity. In contrast, selection exercised by the insured operates in both directions. It may either increase or decrease mortality, and it is possible that two factors working in opposite directions may cancel each other out so that there is no effect on the rate of mortality. An individual might be in poor health and therefore purchase insurance. But the fact that he is in an economic position to afford insurance may mean that he can also afford especially good medical care which may improve his chances of living. Therefore, his mortality, or, more correctly, the mortality of a large number of people like him, may prove to be the same as that of the general population.

The purpose of this paper is twofold. First, to present a statistical comparison of various insured mortality rates with reasonably comparable population data. Second, to analyze the differences in an attempt to determine what selection processes are at work. The following classes of insurance mortality are included in this study: (1) ordinary life; (2) group life; (3) industrial life; and (4) group annuity.

Each of these will be compared to the appropriate population data, and in the final section comparisons will be made among the various types of insured data.

Ordinary Life Insurance Mortality

Ordinary insurance mortality will be represented by the experience of 15 large companies between the 1950 and 1954 policy anniversaries. This experience was published by the Society of Actuaries and served as part of the basic data used in the construction of the X_{17} Mortality Table.[1] The experience is restricted to policies of 16 years duration or greater in order to eliminate nearly all of the effect of insurer selection.

General population rates to be used for comparative purposes will be: (1) U.S. white male rates; (2) U.S. white female rates; and (3) a hypothetical population composed of 85 per cent white males and 15 per cent white females. These population rates will be average rates for the years 1950-1954.

In the comparison of rates for the above groups several methodological problems arise. The first of these results from the fact that the insured data are not strictly comparable with the population rates. For each age interval, population rates are stated as the number of people dying for every 1,000 who were exposed. The insurance rates, on the other hand, are stated as the dollars of death benefits paid per $1,000 of insurance in force. The population rates are pure frequency rates, indicating the number of times the event death occurs, whereas the insurance rates confound frequency and severity and will be influenced by the size of the policy.[2] As an example, consider a group of ten lives, nine of which are insured for $5,000 and one for $55,000. If one of the first nine dies, the mortality rate, based on dollars of benefit over dollars in force, is 1/20; whereas the pure frequency or population rate is 1/10. On the other hand, if the $55,000 policyholder dies, the insurance mortality rate is 11/20 while the population rate is still 1/10. Thus the insurance statistic may overstate or understate the true frequency depending on the relationship between the average size policy in force and the average size death benefit. If these were equal, the individual errors would tend to cancel each other out. For the period under study, 1950-1954, this was not the case. The average size policy was $2,458 while the average size death benefit was $2,727.[3] This means that on an aggregate basis the rates published by the actuaries are approximately 10 per cent higher than the pure frequency rates. In order to correct for this one would have to know the average size policy and death benefit at each age interval. Unfortunately, these data are not currently available. Certain of these figures could be estimated; but since it was not possible to determine the reliability of the estimates, it was decided to use the rates as published by the actuaries, recognizing that they were, overall, 10 per cent higher than the frequency rates.

A second problem arose from the fact that the insurance is mixed in unknown proportions as regards sex. If comparable population groups are to be established, it is important to know what proportion of the hypothetical group is female and what proportion male, since female mortality is materially better than male at all ages. An analysis of the ordinary insurance in force during the period 1951-1953 indicated that about 14.9 per cent of the total

[1] Sternhell, Charles, "The New Standard Ordinary Mortality Table," *Transactions of the Society of Actuaries*, Vol. IX, pp. 1-2.

[2] Companies often eliminate the effect of very large losses by setting a limit, e.g., $100,000. Amounts over this maximum are not included in the data in an effort to reduce the effect of severity.

[3] *Life Insurance Fact Book* (New York: Institute of Life Insurance, 1957), pp. 12, 36.

TABLE 1
DEATH RATES PER 1000 BY AGE: 1950–1954

Attained Age (1)	*White Male* (2)	*White Female* (3)	*Hypothetical Population* (4)	*Insured Group* (5)	*Percentage Difference* 100 (1–⅘) (6)
27	1.69	.89	1.57	1.14	27%
32	1.94	1.18	1.83	1.33	27%
37	2.79	1.76	2.64	1.77	33%
42	4.58	2.69	4.30	3.29	23%
47	7.52	4.15	7.01	5.28	25%
52	11.94	6.35	11.10	8.78	21%
57	18.55	9.65	17.22	14.18	18%
62	27.79	15.42	25.93	22.76	12%
67	40.95	24.76	38.52	34.24	11%
72	58.29	39.85	55.52	52.55	5%
77	89.51	68.06	86.29	74.59	14%
82	132.65	110.44	129.32	112.64	13%

Sources: 1. National Office of Vital Statistics, *Special Reports*, Vols. 40, 42, and 44.
2. Sternhell, *op. cit.*, pp. 4-5.

was held by women.[4] A value of 15 per cent was decided upon as a reasonable estimate. Consequently the population rates, which will be compared to the insurance rates, are composed of white male rates with a weight of 85 per cent and white female rates with a weight of 15 per cent.

The following characteristics of the insured-group data must be kept in mind when one interprets Table 1: (1) most of the beneficial effects of selection have been removed, and these rates represent ultimate mortality; (2) the rate at any given age may be higher or lower than the true frequency of deaths over number exposed; and (3) these rates in the aggregate show approximately 10 per cent greater mortality than would result if rates were based on pure frequency. All of these conditions tend to increase the insured rates.

In spite of the above factors, the insured rates are still well below the white male rates for the general population at all ages. One reason for this is that the insured rates contain female lives which produce consistently lower mortality than male lives. This condition also stems from the fact that the average income of insureds is greater than that of the general population.[5] As indicated above, a higher income means a higher standard of living, which usually improves mortality experience. Insured rates are higher than the white female rates; but if true frequency rates were available for the insured group, the two series would be much closer together.

The last column shows the percentage difference in rates between the hypothetical population (85 per cent male and 15 per cent female) and the insured group. It will be seen that there exist substantial percentage differences at all ages, but these tend to decrease as age increases. These differences are significant at all ages at the .001 level on the Chi Square test if there are at least 100,000 individuals exposed at each age. In the insured data the smallest group exposed at any age was over 300,000. Consequently, there is little doubt of the significance of the difference between the two series of rates. The results of the Chi Square test would be interpreted as follows: the probability that the insured group and the hypothetical composite group are samples from the same population is less than 0.001. This result indicates clearly that the use of general

[4] *Life Insurance Fact Book* (New York: Institute of Life Insurance, 1954), p. 17.

[5] *Life Insurance Fact Book*, *op. cit.*, p. 14.

population mortality rates for insurance purposes is not, as yet, justified.

Group Life Insurance Mortality

The data representing group life insurance mortality is composed of the experience of 10 large life insurers under their group term contracts.[6] The experience period covers the calendar years 1951 through 1954. The experience is primarily that of employee groups with a single employer.[7] The mortality rates shown are for rated and non-rated industries combined.

The population rates used for comparative purposes are those for a hypothetical population composed of 90 per cent male and 10 per cent female lives. During the period 1951-1953, women held approximately 11.1 per cent of the group life insurance in force on adult lives.[8] Consequently, a split of 10 per cent female and 90 per cent male lives was taken as closely representing the actual sex distribution within the insured group. The rates shown are all male and all female rates, rather than being restricted to white male and white female rates, since it was assumed that the white-nonwhite distribution within the insured group was similar to that in the general population. The population rates are average rates for the period 1951-1954.

An examination of Table 2 indicates one important problem related to the comparability of the data. It should be noted that the central attained ages for the group life experience are 18, 23, 28, etc. In contrast, the central attained ages for the population data are 17, 22, 27, etc. This means that the population rates are slightly understated as compared with the group rates. This understatement would tend to lessen the percentage differences as shown in column (7).

Column (7) of Table 2 shows that the percentage differences, in spite of the one year understatement in the population data, are substantial at nearly all ages.

[6] "1955 Reports of Mortality and Morbidity Experience," *Transactions of the Society of Actuaries*, pp. 38-50.

[7] "Trusteeship and association cases insuring employees of member employers of the trusteeship or association, and union cases, whether or not insurance depends on continued employment, are excluded." *Ibid.*, p. 38.

[8] *Life Insurance Fact Book, op. cit.*, pp. 16-17.

TABLE 2

EXPOSURES, DEATHS, AND DEATH RATES PER 1000, 1951–1954

Central Attained Age		*Group Life Insurance*			*Population Rate per 1000* (6)	*Percentage Difference* 100 (1–5/6) (7)
Ins. (1)	*Pop.* (2)	*Years Exposed* (3)	*Deaths* (4)	*Death Rate per 1000* (5)		
18	17	1,332,064	1,246	.94	1.34	30%
23	22	4,020,924	4,008	1.00	1.91	48%
28	27	5,443,727	5,844	1.07	1.85	42%
33	32	5,540,100	7,217	1.30	2.17	40%
38	37	5,466,272	10,645	1.95	3.08	37%
43	42	5,055,287	16,981	3.36	4.84	31%
48	47	4,363,803	24,507	5.62	7.71	27%
53	52	3,550,734	32,321	9.10	12.34	26%
58	57	2,833,309	40,419	14.27	18.51	23%
63	62	2,014,086	43,239	21.47	27.35	21%
68	67	1,101,167	35,968	32.67	40.41	19%
73	72	481,127	24,262	50.43	56.28	10%
78	77	189,374	15,086	79.66	86.68	8%
83	82	60,628	7,653	126.23	127.76	1%

Source: National Office of Vital Statistics, *Special Reports*, Vols. 40, 42, and 44.
"1955 Reports of Mortality and Morbidity Experience," *Ibid.*, p. 41.

The quite large differences at the younger ages tend to decrease as age increases. Based on the actual number of exposures shown in column (3) the two rates of mortality are significantly different at all ages at the .0001 level, with the exception of age 83. If the population death rate shown were adjusted one year upward to age 83, it is likely that the insured rate would be significantly different at this age also.

Considered superficially, the difference between the group life mortality rates and the population rates is surprising. *A priori*, one could reasonably argue that the two sets of rates should be quite similar since apparently there are no important selection procedures exercised by the company. In general, the life insurers' efforts in this area are confined to preventing adverse selection on the part of the insured. With negative controls of this type in operation, it would be expected that the company would get a group of insured lives which represented a cross section of the general American population. The exception to this, of course, would be the sex distribution; but this has already been controlled in the hypothetical population rate. However, the fact that there is less than one chance in a thousand that these two sets of rates are drawn from the same population forces one to reject the assumption of similarity and makes necessary an explanation of the differences.

There are at least three factors which account for the lower group insurance mortality. The first is the so-called "actively at work" requirement. Once a group insurance plan has been established, all new entrants must be at work in order to establish coverage initially. This means that the group of lives insured is, at least originally, of such a vitality as to be employed and on the job. A second factor is the treatment of the disability hazard. The coverage offered by the disability provisions generally contained in group life insurance policies is limited. Consequently, many deaths which occur after long periods of disability would not appear in the group life insurance experience, whereas the population experience is based on all deaths. Finally, it is possible that the white-nonwhite distribution among group insured lives differs from that in the general population. Conceivably, there is a higher proportion of white lives in the insured group; [9] and this would account, in part, for the lower group mortality.

Thus, the lower group insurance mortality rates are primarily the result of the insuring agreements in the policy, and, to a lesser extent, the socio-economic conditions affecting racial employment patterns.

Industrial Insurance Mortality

The data and treatment in this section are based entirely on the work of Lew and Spiegelman of the Metropolitan Life Insurance Company as presented to the Society of Actuaries in a recent paper.[10]

The experience underlying Table 3 is that of Metropolitan's industrial policyholders and represents approximately 55 million life-years of exposure for the period 1951-1953. The distribution of exposure by race and sex is as follows: (1) white males, 36 per cent; (2) white females, 51 per cent; (3) nonwhite males, 6 per cent; and (4) nonwhite females, 7 per cent.

[9] In 1955 the South (South Atlantic, East South Central, and West South Central regions) accounted for 22 per cent of all the group insurance in force, whereas it contained about 31 per cent of the total population. The percentage of nonwhites in the South (22 per cent) is approximately twice as great as in the entire United States, and it accounts for two-thirds of the total nonwhite population in the country. While this does not prove that there is proportionately less group insurance written on nonwhite lives than on white lives, it certainly favors such a conclusion.

[10] Lew, Edward A. and Spiegelman, Mortimer, "The Mortality of Industrial Policyholders, 1950-1955," *Transactions of the Society of Actuaries*, Vol. IX (1958), pp. 149-187.

TABLE 3

MORTALITY OF METROPOLITAN LIFE INSURANCE COMPANY INDUSTRIAL DEPARTMENT AND GENERAL POPULATION OF UNITED STATES COMPARED IN 1951–1953

Age Period	*Percentage Ratio of Death Rates: M. L. I. Co. to U. S., 1951–1953*			
	White Males	*White Females*	*Nonwhite Males*	*Nonwhite Females*
1–74	105%	100%	79%	81%
1–4	92	91	58	59
5–14	86	100	89	71
15–24	81	71	82	78
25–44	104	94	71	76
45–64	117	110	76	76
65–74	110	109	96	97

Source: Lew and Spiegelman, *op. cit.*, p. 153.

In analyzing and discussing Table 3, the authors point out that:[11]

> . . . (for) the period of 1951-1953, the aggregate mortality of white industrial policyholders at ages 1-74 is now practically identical with that of white persons in the general population of the United States; there is, however, an advantage for the insured concentrated at ages 15-24. For nonwhites the insurance mortality is 80 per cent that of the general nonwhite population. This advantage of nonwhite insured lives is found at all ages, particularly under 65 years. While the standards of selection on Industrial insurance are the same for white and nonwhite lives, the relatively low mortality of the insured nonwhites compared with the general nonwhite population may reflect, essentially, the experience of that social-economic stratum of the nonwhites interested in insurance and able to afford it.

The fact that the mortality rates for white industrial policyholders are close to those of the general white population does not necessarily mean that there are no selection processes operating upon this class of insureds. All whites in the general population are not potential customers for this type of insurance. Typically, industrial insurance is marketed only among the lower economic strata of society; and the mortality experience of the whites in these strata will be higher than that of all the whites in the population. Thus, the mortality of white industrial policyholders is actually better than that of the whites in the economic class from which they are drawn.

Selection factors are operating on both the white and nonwhite industrial insureds, and probably the factors are the same for both groups. Insurer selection processes, though lax in comparison to those employed in ordinary life insurance, will, at least, set a minimum standard of insurability. This procedure must, to some extent, affect the mortality rate favorably. Insured selection will operate in the manner already described by Lew and Spiegelman. The values and attitudes associated with the desire for insurance, and the willingness and ability to pay for it, are probably conducive to a stability in living patterns which will tend to reduce mortality.

Group Annuity Mortality

The data appearing in Tables 4 and 5 represent the experience of 14 large life insurers for the years 1951-1954, as published by the Society of Actuaries.[12] Rates are given separately for male and female experience of single life matured annuities under group annuity contracts. The statistics shown represent the mortality of pensioners regardless of the age at which they retired.

[11] *Ibid.*, p. 152.

[12] "1955 Reports of Mortality and Morbidity Experience," *op. cit.*, pp. 62-68.

TABLE 4

GROUP ANNUITY MORTALITY RATES (MALE) AND POPULATION MORTALITY RATES (WHITE MALE) FOR 1951–1954

Central Attained Age		*Group Annuity Mortality*			*Pop. White Male Rate per 1000*	*Percent Diff. 100 (1–¾)*	*Chi Square Level of Significance*
Ins. (1)	*Pop.* (2)	*Life Years Exposed* (3)	*Deaths* (4)	*Rate per 1000* (5)	(6)	(7)	(8)
53	52	2,691	91	33.82	11.90	−184%	.001
58	57	19,540	792	40.53	18.48	−119	.001
63	62	95,373	3,390	35.54	27.71	− 28	.001
68	67	227,522	8,687	38.18	41.01	7	.001
73	72	100,353	5,586	55.66	57.76	4	.01
78	77	34,478	2,916	84.58	89.35	5	.005
83	82	9,681	1,281	132.32	132.01	0	NS

Source: National Office of Vital Statistics, *Special Reports*, Vols. 40, 42, and 44.
"1955 Reports of Mortality and Morbidity Experience," *op. cit.*, pp. 65-66.

TABLE 5

GROUP ANNUITY MORTALITY RATES (FEMALE) AND POPULATION MORTALITY RATES (WHITE FEMALE) FOR 1951–1954

Central Attained Age		*Group Annuity Mortality*			*Pop. White Female Rate per 1000*	*Percent Diff. 100 (1–¾)*	*Chi Square Level of Significance*
Ins. (1)	*Pop.* (2)	*Life Years Exposed* (3)	*Deaths* (4)	*Rate per 1000* (5)	(6)	(7)	(8)
53	52	2,322	28	12.05	6.28	−92%	.001
58	57	9,416	108	11.47	9.51	−21	.1
63	62	24,475	360	14.71	15.22	3	NS
68	67	28,343	556	19.62	24.65	30	.001
73	72	10,579	355	33.56	39.16	14	.005
78	77	3,988	236	59.18	67.60	12	.05
83	82	1,154	132	114.38	109.92	− 4	NS

Source: National Office of Vital Statistics, *Special Reports*, Vols. 40, 42, and 44.
"1954 Reports of Mortality and Morbidity Experience," *op. cit.*, pp. 65-66.

Population rates are for white males in Table 4 and white females in Table 5. They are average rates for the period 1951-1954. White male and female rates are used for comparison, rather than all male and all female rates. This procedure was followed as it is probable that there were few nonwhite pensioners under group annuity contracts during the period studied, especially since under 200,000 pensioners were included in the study.

An examination of column (7) of Tables 4 and 5 shows that the relationship between male and female annuitants and their respective population groups is quite similar. In both cases annuitant mortality prior to normal retirement age (65) is substantially higher than the population mortality. This is true as most early retirements are the result of disablements, either partial or total; and mortality among disabled lives is, in general, heavier than that of non-disabled lives. Probably a higher proportion of early retirements due to disablement occur among males than among females. This is reflected in the data which show that the percentage differences prior to retirement are greater for males than for females.

For ages greater than 65 the mortality of pensioners is lower than that of the population, but the percentage differences decrease with age and disappear by age 83. This advantageous mortality may be accounted for by three factors. First, since widespread acceptance of and use of

pension plans is a fairly recent development, it is possible that the people drawing pensions during the years 1951-1954 do not represent a random sample of all workers covered by pension plans. Rather it is likely that the annuitant group of this period contains an abnormally high proportion of top management executives. These people would be in the upper income brackets and would have a higher standard of living, which generally is associated with lower mortality rates. A second factor tending to reduce annuitant mortality is the existence of the pension itself. A person receiving a pension is obviously in a better position to maintain his standard of living. One of the important items which a pension income will help to cover is the cost of medical care, and the extent and quality of medical care will directly affect the rate of mortality. Finally, the fact that the annuitants are able to work until retirement indicates a good physical condition and presumably lower mortality.

Column (8) of Tables 4 and 5 shows the level of significance of the difference between the two rates under consideration on the Chi Square test. A figure of .001 would be interpreted to mean that there is one chance in a thousand that the insured group represents a random sample from the population group. The cases in which there is no significant difference, particularly in the female mortality, are probably the result of an insufficient number of life years exposed. These cases are, therefore, inconclusive, and should not necessarily be interpreted to mean that annuitant and population mortality are the same. Because of the limited number of exposures it is not known if there are significant differences between the two groups.

In the examination of Tables 4 and 5, the one year age differential, as indicated in columns (1) and (2), between the annuitant and the population groups, should be kept in mind.

Comparison of the Mortality of Various Types of Insured and Annuitant Groups

In previous sections we have compared insured and annuitant mortality rates with comparable population groups in an effort to determine what, if any, significant differences exist between the death rates for

TABLE 6

MORTALITY RATES PER THOUSAND FOR ORDINARY LIFE INSURANCE (1950–1954), GROUP LIFE INSURANCE (1951–1954), INDUSTRIAL LIFE INSURANCE (1950–1953), AND GROUP ANNUITIES (1951–1954), MALE AND FEMALE

				Group Annuity			
Age (1)	*Ordinary* (2)	*Age* (3)	*Group Life* (4)	*Male* (5)	*Female* (6)	*Age* (7)	*Industrial* (8)
		18	.94			15	.68
		23	1.00			20	1.06
27	1.14	28	1.07			25	1.25
32	1.33	33	1.30			30	1.50
37	1.77	38	1.95			35	2.14
42	3.29	43	3.36			40	3.42
47	5.28	48	5.62			45	5.42
52	8.78	53	9.10	33.82	12.05	50	8.33
57	14.18	58	14.27	40.53	11.47	55	12.51
62	22.76	63	21.47	35.54	14.71	60	18.78
67	34.25	68	32.67	38.18	19.62	65	28.87
72	52.55	73	50.43	55.66	33.56		
77	74.59	78	79.66	84.58	59.18		
82	112.64	83	126.23	132.32	109.92		

Source: "Industrial Mortality Rates," Metropolitan Life Insurance Company, *Statistical Bulletin*, Vol. 32, (August, 1951), p. 2; Vol. 33, (September, 1952), p. 2; Vol. 34, (August, 1953), p. 5. For all other rates see previous tables.

TABLE 7

MORTALITY RATES FOR ORDINARY, GROUP, AND INDUSTRIAL LIFE INSURANCE AND GROUP ANNUITIES SHOWN AS A PERCENTAGE OF CSO 1941 RATES

				Group Annuity			
Age (1)	*Ordinary* (2)	*Age* (3)	*Group Life* (4)	*Male* (5)	*Female* (6)	*Age* (7)	*Industrial* (8)
		18	41%			15	32%
		23	37			20	44
27	37%	28	33			25	43
32	34	33	32			30	42
37	34	38	36			35	47
42	47	43	45			40	55
47	53	48	53			45	63
52	61	53	58	219%	78%	50	68
57	68	58	63	178	51	55	70
62	73	63	64	105	44	60	71
67	74	68	65	76	39	65	73
72	75	73	67	74	44		
77	72	78	71	75	53		
82	73	83	76	79	66		

insured lives and the general population. This section deals with the comparison of mortality among insured and annuitant groups. It is limited in scope to the types of annuitant and insurance mortality already described.

Table 6 contains mortality rates per thousand for the insured and annuity groups indicated. The rates are the same as those shown in previous tables, except for industrial mortality. The industrial rates are based on the experience of the Metropolitan Life Insurance Company for the years 1950-1953.

Table 7 shows the rates contained in Table 6 expressed as percentages of the rates in the Commissioners' 1941 Standard Ordinary Table. Thus for any rate the percentage would be determined by the formula: $100\left(\frac{q_x}{q_x \quad (CSO)}\right)$. The CSO table was used as a basis since this is the table most commonly referred to in insurance literature and a comparison with it indicates to what extent it overstates the actual mortality experience. Further, it gives a general idea of mortality improvement since 1930-1940. However, the improvement is somewhat less than that indicated by the percentages in Table 7, since the CSO rates contain margins over the actual experience rates.

Charts 1 and 2 show the mortality rates contained in Table 6 plotted and connected by freehand curves. Chart 1 exhibits the rates for ages 15 to 53, and Chart 2 for ages 50 to 83.

An examination of Charts 1 and 2 leads to the following conclusions: (1) among the three main types of life insurance, group insurance has the most favorable mortality, being slightly lower than the ultimate ordinary experience at all ages; (2) industrial policyholder mortality is substantially higher than the mortality of either ordinary or group insureds, although at ages greater than sixty the differences between ordinary and industrial mortality appear slight; (3) group annuity mortality rates over age 65 tend to bracket the insured lives' mortality rates, with male annuitant mortality being higher and female annuitant mortality being lower; (4) if a single group annuity mortality rate were formed, based on weighted averages of the male and female rates, it would follow quite closely the pattern of group life insurance mortality for ages above 65. Since pensioners and group life insurance policyholders are

CHART I

MORTALITY RATES UNDER ORDINARY, GROUP, AND INDUSTRIAL LIFE INSURANCES FOR AGES 15-53

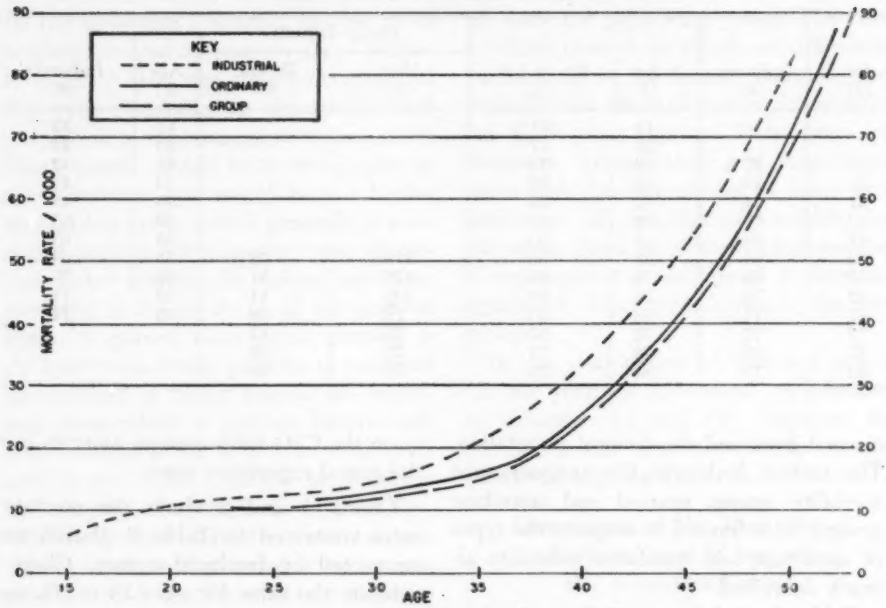
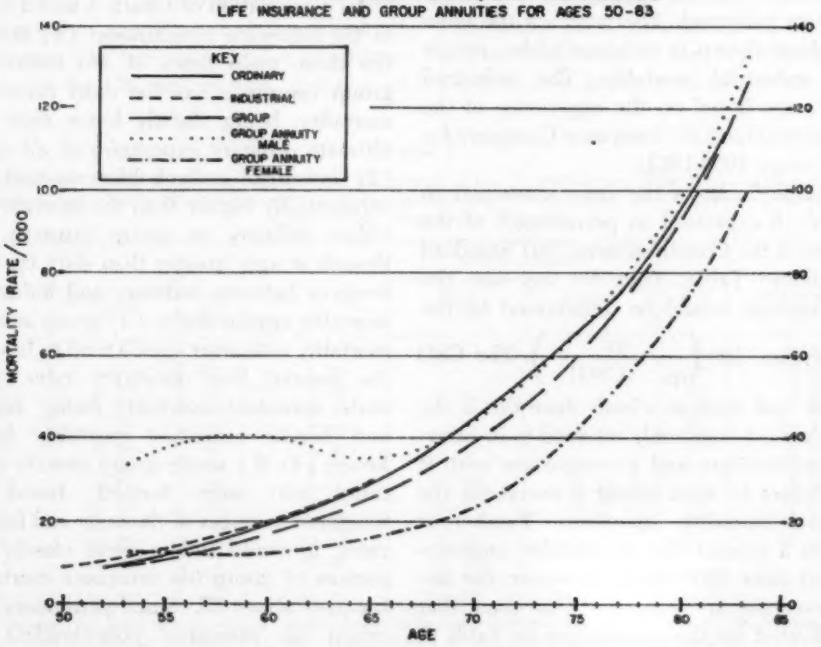


CHART 2

MORTALITY RATES UNDER ORDINARY, GROUP AND INDUSTRIAL LIFE INSURANCE AND GROUP ANNUITIES FOR AGES 50-83



drawn from essentially the same population, i.e., the labor force, the last conclusion is what one might expect.

Conclusions

1. Even after largely eliminating the effects of medical selection, mortality rates under ordinary insurances are significantly lower than those in the general population.

2. Group life insurance mortality rates are significantly lower than those of a comparable population group.

3. Industrial mortality for white policyholders is at about the same level as that of the white population. Nonwhite industrial mortality is substantially better than that of the nonwhite population.

4. Group annuitant mortality for ages under 65 is much higher than that of comparable population groups. For ages over 65 mortality rates of group annuitants are significantly lower than those in the general population.

5. Arranging (from high to low) the various types of insured and annuitant mortality examined in this study the following array results:

(1) male group annuity mortality
(2) industrial insurance mortality
(3) ordinary insurance mortality
(4) group insurance mortality
(5) female group annuity mortality

SOME OBSERVATIONS ON EXPERIENCE RATING IN UNEMPLOYMENT INSURANCE

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In the Commonwealth of Pennsylvania on January 1, 1958, the Unemployment Trust Fund showed a balance of approximately $345 million. By the end of that year there was a balance in the fund of about $125 million. The reserves accumulated to meet just such contingencies as the recession had been depleted substantially during the year. Under these circumstances one might well ask, "Is the system soundly financed? Is the present tax law adequate to restore reserves speedily and to provide continuing security for the system?" It was such questions as these which gave rise to this and a number of related studies.

The basic function of this present study is two-fold: first, it is designed to test the adequacy of a reserve-ratio system for dealing appropriately with exposure and experience patterns as they exist in Pennsylvania under present law. Limitations, if there are such, and the reasons therefor, must be discovered. Among other things, it must be determined whether the limitations are legislative in origin or whether they are inherent in such a system. Secondly, the study aims to analyze a number of alternative techniques of experience rating with a view to establishing whether any one will deal with the Pennsylvania problem more effectively than the present scheme. This calls for decisions as to what constitutes equity in cost distribution, which costs should be shared, and what elements of experience should be used to measure the costs as a basis for charging the originating account. Therein lies what is really a third phase of this study: testing hypotheses with a view to presenting technical evaluations of the range of available alternatives.

Historical Observations

Experience rating was instituted in Pennsylvania in 1944. The system employed a combination of the reserve-ratio and benefit wage ratio systems. A modified state reserve ratio was used to test the state fund's adequacy, that is, to provide a basis for determining the particular experience rate schedule to be applied to employer accounts. A benefit wage ratio was used to measure employer experience and set employer rates within any given schedule. Rate schedules providing for rate assignments ranging from 1.0 per cent to 2.7 per cent of taxable payroll were provided. In addition, the law included a so-called "fund stabilization factor" by means of which rates were further adjusted periodically.[1]

The above technique was used until 1949, when a form of the present reserve ratio system was adopted. A commentary by Rachel S. Gallagher on this change is significant. She said:

[1] The law provided that if the state ratio were 8.3 per cent or more at the beginning of a calendar year, the rates were to be adjusted downward. If at the beginning of any calendar quarter the ratio were below 8.1 per cent, tax rates were to be adjusted upward.

> The Pennsylvania legislature in 1949 changed from the benefit wage system of experience rating to a reserve ratio system. The change was made in anticipation of the higher rates that would be imposed under the benefit-wage plan because of the effect of increasing benefit costs on the wage factor. Those sponsoring the plan recognized that these additional costs should be met by the excess contributions collected during the years of high employment rather than by increasing future revenue by means of higher rates. The change to a reserve ratio system of experience rating means that the rates of individual employers reflect contributions accumulated in earlier years. . . .[2]

In effect she concludes that the high sensitivity of the benefit wage ratio system would have produced rising tax rates in 1949 and that this was a major factor in the adoption of the reserve ratio system. Such a system, theoretically, was to be less sensitive. It had the effect of reducing tax increases which otherwise would have become effective.[3]

The rate stabilization characteristic of the reserve ratio experience rating plan, however, was vitiated in Pennsylvania by the adoption in 1949 of a multi-schedule provision. The effects of increasing benefit costs and declining wages caused a lowering of the state-wide reserve ratio, as well as many employer reserves, with a resulting shift to a higher tax schedule and higher employer tax rates. Thus, the new system preserved the fluctuation feature of the old rather than modifying it as proponents argued that it would.

During the period of 1949 through 1958 the reserve ratio technique was used continuously, subject to several legislative modifications. In 1951 the tax structure was modified so as to reduce employer rates retroactively by a crediting procedure. This involved development of a new system of reduced rate schedules and reserve requirements, for both the state and employers. This was done on the theory that the total reserve for the commonwealth was higher than needed and that some reduction in tax rates thus was feasible. In that same year an actuarial study was conducted which indicated the range of potential costs and suggested a mean average contribution rate which was higher than that established by the new schedule. In that same year benefits were also increased, which had the effect of further aggravating the financial problem.

Further modifications in 1953 produced a similar situation, viz., reductions in rates and increases in benefits.[4] Only minor changes have been made in the basic experience rating procedure since 1953. However, benefits have been increased and their duration extended, both of which changes acted to increase the costs of the system.

Under the provisions of the reserve ratio plan, Pennsylvania employers paid taxes on the minimum schedule in 1953, the intermediate schedule in 1954 and 1955, and the maximum reduced-rate schedule in 1956. The latter rate level was a result of the 1955 recession experience. The increase in tax yield in 1956, together with reduced benefit payments as a result

[2] Rachel S. Gallagher, "Trends in Unemployment Insurance Financing," *Social Security Bulletin*, October, 1949, p. 6.

[3] It may be noted that during this period (1944-49) of the benefit wage ratio system, reserves grew in all years except 1946. Since the change to the reserve ratio system (1949) reserves have grown in only two of the subsequent years, 1951 and 1956. This fact is not due solely to the change in rating system, however. Legislative modifications in contribution requirements, and benefits and economic factors in subsequent years have also been important. The average rate required in 1949 it will be noted, was reduced by the shift in rating system base, however.

[4] It may be noted, for example, that substitution of a fixed amount state reserve base in lieu of the percentage table proposed in 1951 had had the effect of reducing the adequacy of reserves as measured by a relationship to taxable wages by about ten per cent from 1951 to 1953 simply as a result of wage increases over that period. The same limits have been maintained since, despite the effects of continued inflation in wages.

of better economic experience, raised the year-end reserve enough to restore the intermediate experience rating schedule for 1957. However, the drain on the state fund to pay increased benefits as a result of the recession in the latter half of 1957, together with declining contributions with the decrease in taxable payroll, necessitated a return to the maximum experience rating schedule for the year 1958. Despite this, the continuing benefit drain during 1958 has seen the reserve for the State depleted substantially, with the result that there can be no experience rating in 1959 unless the law is changed. All employers are required to contribute at the maximum under present legislation.[5]

The rating system used in Pennsylvania clearly has not been entirely satisfactory either in stabilizing costs or in maintaining theoretical adequacy. Part of this is probably due to piecemeal modification of the law; part is due to the inadequacy of the underlying economic assumptions implicit in that law concerning expected experience; and part is due to the experience rating device itself, which has been adjusted from time to time without, in this writer's opinion, too much justification in fact.

It is to be noted that the 1959 session of the Legislature amended the Act providing for experience rating effective Jan. 1, 1960, regardless of reserve size. However, the range of rates was from 1.6 to 4.0 per cent of covered wages.

It is the experience rating technique with which this study is primarily concerned. Certainly there must be various means of measuring experience and promulgating rate schedules which achieve "equity" while preserving adequacy. To determine this is the subject of this inquiry, and it is to this point that the principal research has been and will be directed.

Factors Affecting Experience Rating

A number of factors are involved in the formulation of an experience rating system. Contributions to the system must be related to the probability of loss and the volume of exposure. Probability of loss depends upon the unemployment experience in the state. The extent of exposure depends upon the number of people employed in the state, wage rates, number of hours worked, and the benefit schedule. Attention will now be given to the effect of changes in these factors on loss cost.

An increase in payroll may connote increased employment, higher wage rates, or more hours of work. If employment increases, there are more potential beneficiaries and more wage credits are accumulated. This means greater exposure to loss and greater potential liability for the system. If wage rates increase or more hours are worked, potential liabilities would also increase if a higher benefit level results or there is developed a longer period for which employees may draw benefits.[6]

[5] The minimum state reserve to permit experience rating is $300 million. The year end balance was about $125 million. Actual reserves, taxable wages and reserves as a per cent of taxable payroll since the inception of experience rating in Pennsylvania are as follows:

Year	*Taxable Wages (millions)*	*Fund Balance (millions)*	*Fund as a Percentage of Taxable Wages*
1944	$5,433	$561	10.33
1945	5,286	608	11.50
1946	5,756	587	10.20
1947	6,650	608	9.14
1948	7,172	636	8.87
1949	6,882	571	8.30
1950	7,268	535	7.36
1951	7,954	607	7.63
1952	8,180	558	6.82
1953	8,481	553	6.52
1954	7,952	392	4.93
1955	8,154	345	4.23
1956	8,509	382	4.48
1957	8,598	344	4.00

Source: *Pennsylvania Unemployment Compensation Fund Contributions, Interest, Benefit Payments, Fund Balance 1937-57*, Statistical Information Bulletin, No. 126, August, 1958, page 8.

[6] It will be noted that since 1949 Pennsylvania has passed through three periods of cyclical expansion and two of decline, each of which has differed in effect on various industries and in intensity and time.

If these effects do not appear, the increases would have no significance. A decrease in payroll or decreased employment also needs to be measured. If experience rating is to be used to reflect the potential liability of the system, the contribution from the subject account should reflect these changes.

Each change discussed above poses problems with regard to the financial operations of an unemployment insurance system. The cause of change may produce further complications. Increases or decreases in employment stemming from the status of the business cycle create one type of problem. Changing levels of employment stemming from secular growth or decline in the economy create a different type of problem.

Cyclical movements, for example, have varying effects on employment in different industries. The length and depth of depressions have a great influence on the amounts of unemployment benefits paid. The cause of the recession and the general state of the economy at the time the recession begins will also affect the overall cost of unemployment benefits.

Seasonal change in business can also produce unemployment. Here the causes of loss (fluctuations in levels of employment and unemployment) are associated with the weather, holidays, vacations, and the like. In some states such losses have been responsible for as much as 30 per cent of the costs of benefits in some years, and in nearly all cases account for 20 per cent or more of the total benefit outlay.

A third factor of real significance in some states, including Pennsylvania, has been technological change. Historically and currently this factor affects all elements of the economy, although the relative incidence has been greatest in the older industrial states and in two or three industry groups (e.g., in Pennsylvania: coal, textile, apparel, and, more recently, steel). Here as in each of the previously noted cases, the problem of equity in sharing losses is most significant. The real question is to what extent all industry, as opposed to the industry of origin, should contribute to these burdens. Another question, of course, is the extent to which costs of constructive unemployment should be shared or borne by the industry of origin.

Personal factors are an important cause of unemployment. An employee's desire to change his place of employment tends to fluctuate with changing circumstances either in the economy or in the life of the individual. One may well question whether the costs of such unemployment should be covered. If the decision is an affirmative one, there is the further question whether this cost should be related to the industry of origin or to industry as a whole. It would seem that an entire industry should not be charged these costs. This poses a special factor for analysis, as most states do not charge the employer account for such costs. These charges then become "social." The question then remains as to how such charges should be shared in terms of reducing both state and employer reserves.[7]

The above variables, along with others, pose the problem of which costs should be borne by individual employers in proportion to loss and which ones should be shared equally by all. This would be a relatively complex but soluble problem if

[7] New York, Wisconsin, and Florida, for example, have developed techniques for charging costs of these types against all employers. In these cases the experience rating system does not react to charges resulting from these types of losses except in general. All employers are affected proportionately in the same way at the same time. Employer reserves are not affected by relieved charges—except to the extent that an employer shows that benefits paid to his employees fall in this category, thus reducing the incidence of total specific charges against his account. All share in these costs; and because they are allocated to the State Fund and offset by proportionate employer account debits, the effect of this turnover is immediate and is shared immediately.

this were strictly private insurance. The criteria outlined could be weighted statistically to reflect the state or industry pattern and premiums adjusted accordingly. But this is not private insurance. It is a social insurance program, and the problems of what risks society wishes to cover and in what manner become primary to the making of program financial policy. Similarly the problems of distributing costs are resolved on other than pure statistical bases. These are, in fact, basic decisions in social policy; and more often than not they require a political rather than a technical decision, although the former may be based upon the latter.

To assist in making these decisions, considerable analyses of fluctuations and their financial effects must be conducted. It is evident that if the simple insurance device is to be used on a social base, nothing other than a computation of average loss is necessary. But if experience rating is to be used, then the basis for planning such a financial program must lie in the purpose to be achieved and the patterns of reaction to change in the economic universe tested.

The first purpose is to reduce unemployment by encouraging employers to stabilize employment. To accomplish this result against cyclical fluctuation, for example, appears difficult, if not impossible in many cases, especially in view of the amount of saving which can be attributed to experience rating as such, given the maximum rate framework evident in many states. To overcome the seasonal patterns may be easier, depending on the production pattern, although again the question of the value of rate reduction (within the rate framework given) versus labor cost savings must be carefully considered.

It seems easy to achieve the purpose of an equitable cost distribution in the light of experience—and this may stimulate stabilization to some extent. However, the question of the social basis for cost distribution is not easy of solution. From a technical viewpoint there are two types of considerations. First, one must determine which costs are to be shared, i.e., which costs are to be charged to employer accounts in general, and which costs are to be individually borne. This point is already treated to some extent by the law in that all share in losses above a level of 2.7 per cent of covered payroll. Some now question whether this is an appropriate level to be used as a basis for this decision.

Second, the question of how to distribute costs over time is equally important. Such problems as how to obtain a counter cyclical rate function, for example, must be considered. The equity of transferring costs to stable employers in the form of higher rates in times of decline as compared with charging all employers more during periods of expansion must be determined.

In fact, one must probe the entire area of experience to isolate causes of variation. Then, one must pose the policy alternatives. Such questions as the following point up to the kinds of judgments which must be made. To what extent should a firm in a declining industry, or one in which an historical structure is being superseded by technological change, be required to contribute to the specific costs associated with the unemployment resulting from such decline? To what extent are the causes of technological unemployment the result of a firm's failure to adopt new ideas? To what extent should development of new ideas result in new employment and hence the ability to pay by increasing total purchasing power? To what extent is constructive unemployment a problem which must be borne individually or collectively? [8]

[8] To the point up the problem, one may question the relative effects of charging a declining firm the full cost of its experience, which brings up the possibility of its immediate failure with the resulting loss of work for all its employees

With regard to seasonal change, one may be prompted to ask questions such as the following: To what extent does the economy of the state depend upon seasonal industry and, in this sense, to what extent do fluctuations due to seasonal changes become proper social costs which should be borne by all employers jointly? To what extent should employers who operate in seasonal industries be required to assume a disproportionate share of the costs of seasonal fluctuations as a normal cost of doing business?

The question of cyclical fluctuations must be considered. Here, questions in two different contexts must be raised. First, one must decide whether or not the costs of cyclical unemployment should be shared equally among all employers on the basis of exposure. One must also determine whether or not the costs of unemployment due to the cycle are outside the control of the individual firm. On the other hand, one may ask why the costs should not be shared in proportion to their incidence since they are costs of doing business and are related directly to specific types of industry. In either case, one must also ask whether or not the costs should be distributed evenly through the cycle, thus averaging costs, or be reflected in rate adjustments as losses occur in time. In addition, one may ask whether or not the reserve should be accumulated during years of growth so that losses may be shared in proportion to potential liability. Consideration of these policies by the reader will make the implications of each of these techniques for declining, growing, stable, unstable, seasonal and non-seasonal firms apparent. The reasons for political and social considerations are also evident from the results which would be attained in each instance. Time and space do not permit detailing them here.

Depending upon the conclusions drawn from the substance of the answers to these and related questions and the economic philosophy of the governing body, decisions concerning criteria for measuring the hazard and rating can be developed. As a basis for evaluating the alternatives, an analysis of the costs of unemployment by cause and by industry for a period of time must be prepared. With these data, alternative techniques of cost distribution may be tested to show the practical results of utilizing each of the different methods both upon the state fund and upon a representative sample of individual employer accounts of all types.

For example, detailed analyses of variations on the reserve ratio technique, such as extension of the average period, can then be tested to show how costs are distributed among the various types of firms and through time. Similar analyses of the results with use of the benefit wage ratio system, the benefit ratio system, the compensable separations system, and the payroll variation system, together with the many potential variations on each, may be prepared. With these data it will be possible to judge each technique with regard to its effectiveness in adjusting to seasonal, cyclical, secular, and other types of fluctuations. In addition, our work will include experimentation in the same manner with certain other measures of exposure and degree of risk, such as employment.

While professionals in the field of insurance can make judgments concerning the adequacy of any technique, given the objectives, and can offer recommendations as to a sound technical basis for cost distribution, the decisions, in the last analysis, must be made by the Legislature.

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and consequently high benefit charges against the fund, as opposed to reducing the immediate likelihood of failure through minimizing costs of unemployment by sharing a part of the burden of decline among the employer group as a whole, thus permitting a transition period for readjustment. This decision has both economic and political ramifications and is one which cannot be resolved except by the Legislature.

Recognizing this, our function is to present all the facts concerning all the possible variables which can be used in any way as a basis for decision-making.

Concluding Observations

On the basis of our research, it is concluded that the costs of unemployment can be measured and allocated in monetary terms. These costs may be pooled and shared equally, or an appropriate method for transferring the risk and proportions of cost can be designed. Sound insurance principles would suggest that these costs must be shared basically in terms of differences of exposure, and of frequency and severity rates. However, as was noted earlier, this is a social insurance scheme, and other considerations must enter into the design. Thus, experience rating systems as devices to allocate costs based upon differentials in exposure, frequency, and severity, although completely consistent with insurance principles, may not be used in their entirety, or at all, if social policy is better served otherwise.

It is our view that whatever system is adopted must be sound in the sense that the average contributions levied must through time equal costs. Similarly, it must be retained through sufficient time to permit the functioning of the system to accomplish this objective, despite fluctuations which occur to the disadvantage of some at various times. Alteration of the mechanism of contribution or the basis for rating merely because some short run gain for some employer accounts would result, cannot be tolerated if the overall solvency of the system is to be maintained. Failure in this sense would lead to the development of an *ad hoc* program to replace the orderly and stable distribution of costs over time as contemplated by the system. The results would be the chaos of expediency assessments resulting essentially from the current sharing of unemployment benefits.

INVESTMENT INCOME AND CASUALTY INSURANCE PROFITS

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During the recent recession* most businesses experienced difficulties of some sort—high costs, slackening demand, intensified competition—which decreased their profits or resulted in losses. The stock insurance companies that do the bulk of their business in the so-called casualty lines experienced much the same sort of profit squeeze, but their problems during this period could not be attributed primarily to the economic recession. In fact, their problems have persisted as the recession problems of other businesses gradually disappear. It is the other face of the present Janus-type economic conditions that have caused these companies' problems—inflation. Losses and costs, relatively speaking, have been increasing steadily in most of the casualty lines. Jury awards and out-of-court settlements in personal liability cases have gained momentum from an increasing price level and more effective trial procedures developed and disseminated by such organizations as the National Association of Claimants' Compensation Attorneys. Claims for physical damage have increased as automobiles and property in general have become more expensive and complicated. The cost of adjusting claims has also tended to rise in recent years. Other lines such as accident and sickness insurance and workmen's compensation have not been affected as adversely profit-wise, but the stock companies are still faced with stiff rate competition from the mutual companies for this business.

Stock bureau casualty companies have been at a great disadvantage when competing with independent or deviating stock and mutual companies which tend to charge lower premiums (after dividends in the case of some mutuals) for similar coverage. Needless to say, the lower premium companies are able to select the most desirable business from the available risks and thus leave the less desirable business for the higher premium companies. This relatively poorer class of business increases the bureau companies' loss costs, thus necessitating an upward rate revision which worsens these companies' competitive situation still more. The bureau companies are thus caught in a vicious circle of circumstance that can only be remedied by a material cost reduction in some phase of their operations that would enable them to compete effectively with the currently lower premium companies for good business. The most remarkable aspect of this situation is that it has existed, in varying degrees, for many years; and the fundamental operating changes that seem to be needed to mitigate it have not been forthcoming.[1]

Bureau companies have been able to survive despite keen competition and substantial cost handicaps for several rea-

* This article was written and submitted for publication in early 1959.

[1] Various rate-cutting devices have been used by bureau companies from time to time to attract more business, but this usually results in commensurate rate reductions by competitors. The most recent example of this type of rate-cutting is the Safe Driver Insurance Plan initiated in California by the National Bureau of Casualty Underwriters and the National Automobile Underwriters Association. This plan is based on a three year experience period, and it is generally held that such a plan is not actuarially sound unless it is based on a much longer period of time—e.g., ten years. C. A. Kulp, *Casualty Insurance*, 3d ed., New York: Ronald Press Co., 1956, pp. 512-513.

sons: (1) The agency systems developed and maintained by these companies have provided service for customers that has created a great deal of good will and has enabled these companies to retain much of their business; (2) Advertising, especially by the larger companies, has helped; (3) The headstart and momentum many of these companies achieved during their long corporate history have contributed; (4) The investment operations of these companies have been profitable—in some cases much more so than underwriting operations. The latter point is the subject of this paper.

Importance of Investment Profits

A recent sample of stock and mutual casualty companies by the author revealed the following relationship between investment profits and total profits over the period 1926-1955:[2]

	Investment Profits as a Percentage of Total Profits	
	Stock Companies	Mutual Companies
Large Companies	75.6	17.6
Medium Companies	45.4	27.7
Small Companies	55.2	25.6

On the basis of these data it would seem reasonable to conclude that stock companies, especially the large ones, have relied heavily on investment operations in achieving their total profits.

[2] R. G. Schultz, *Casualty Insurance Experience and Profits*, University of Pennsylvania, 1959, pp. 153-185. The sample consists of thirty companies, broken down into six groups of five companies each by asset size and legal form.

Stock Companies
Large size—over $50,000,000
Medium size—$10-$50,000,000
Small size—under $10,000,000
Mutual Companies
Large size—over $25,000,000
Medium size—$5-$25,000,000
Small size—under $5,000,000

The data given above are before the payment of federal corporate income taxes (if any) and the declaration of dividends.

The Regulation of Investment Profits

Casualty insurance is an economic function so closely related to public welfare that it is carefully regulated, in varying degrees, by the states. Much of this regulation is concerned with the setting of rates, which must not be excessive, inadequate, or unfairly discriminatory; but no such standard, however vague or indefinable, is applied to investment income or profits. This situation is not unique to casualty insurance, as fire and marine insurance rate regulation similarly ignores investment profits.

Profits in casualty insurance have never been defined by law. Prior to 1946 they had scarcely been mentioned. Unlike fire insurance, with its 1921 Standard Profit Formula (revised in 1949), casualty insurance has no approved or recommended profit formula. However, regulatory officials apparently applied the following principle embodied in the 1921 Standard Profit Formula to casualty insurance: "No part of the so-called banking profit (or loss)[3] should be considered in arriving at the underwriting profit (or loss)."[4] The basis for this provision is even more amazing than the provision itself. The chairman of the 1921 National Board of Fire Underwriters Committee made a compromise with the National Convention of Insurance Commissioners Committee (currently the National Association of Insurance Commissioners) by which the NBFU would lower its conflagration allowance request from five per cent to three per cent if the NCIC would eliminate investment income from

[3] The term "banking profit" refers to the profits earned from the investment operations of the companies. The part of investment income that has been considered most frequently in relation to rates is that amount which is attributable to policyholders, i.e., that portion of investment earnings resulting from the investment of policyholders' premiums.

[4] Proceedings of the Fifty-Third Annual Session, National Convention of Insurance Commissioners, p. 20.

consideration in setting the amount of profit.[5]

This principle was not challenged until 1951 in casualty insurance rate regulation. Despite the fact that the casualty insurance industry has never had a specific profit formula, the rate structure has included a loading factor for profit (and contingencies) for many years. The National Association of Insurance Commissioners did not stipulate that the casualty companies could have a profit and contingencies allowance, but the right was not denied. In fact there was an implied acquiescence by NAIC that the casualty companies could so load their rates. The National Bureau of Casualty Underwriters, for example, included a 2.5 per cent profit and contingencies factor in certain of the rates as early as 1924.[6] State insurance departments approved rates with such a factor despite the lack of an officially-sanctioned profit formula. Such acceptance on the part of regulatory officials did not change until the NBCU began to increase the size of some of its factors in the late 1940's.

The NBCU 2.5 per cent profit loading was accepted for two reasons. First, the profit formula approved by the NAIC for fire companies was a precedent. The only part of the 1921 Standard Profit Formula not applicable to casualty rates was the catastrophe allowance.[7] Secondly, the 2.5 per cent profit factor seemed reasonable. It provided for both profits and contingencies, while the fire company allowance of 5 per cent was for profits alone. Although casualty companies write more business per dollar of policyholders' surplus than do fire companies,[8] their 2.5 per cent allowance would only have been more profitable than the 8 per cent profit and catastrophe allowance of fire companies if they did 3.2 times as much business as fire companies. Since they wrote only about twice as much business per dollar of policyholders' surplus as fire companies, the latter clearly had the more generous allowance. Hence, if the fire companies' allowance was acceptable to

[5] Kurth gave the following testimony in a Kansas rate case: "Some of the commissioners, notably the commissioner from North Carolina, felt that some consideration should be given, in calculating the underwriting profit especially as the basis for determining rates, to the interest income or earnings on the invested—the unearned premium reserve—this was gone into very thoroughly and the difficulties of arriving at a practical rate to be used were considered unsurmountable, in fact some of the commissioners even agreed that the cost of accurately determining the earnings on the reserve would be more than the actual earnings: to meet these views the National Board Committee agreed to reduce the conflagration allowance from 5 to 3 per cent, and make it a variable figure to be increased or decreased as the experience over a period of years demonstrated whether 3 per cent was too high or too low." Quoted in *The National Board of Fire Underwriters Reply to the McCullough Report*, p. 24. Commented Roy McCullough of the New York Insurance Department: ". . . Twenty-five years hindsight indicates the wisdom of the compromise is highly debatable. First of all, the problem of conflagration allowance and the problem of consideration of investment earnings, are two entirely separate propositions which should hardly be offset one against the other. . . . Further, it is again repeated that the investment earnings excluded from consideration were actual earnings, while the conflagration allowance that was reduced was a paper figure that had never been attained. The companies had, in effect, asked for a 10 per cent underwriting profit, a figure which they had never attained in the eleven years prior to the adoption of the formula. It was a figure that was unsupported and when the conferees agreed to the complete elimination of all investment earnings from consideration in exchange for a reduction in the 10 per cent figure, it was a one-sided compromise." *Proceedings* of the Seventy-Ninth Annual Session of the National Association of Insurance Commissioners, p. 275.

[6] *Proceedings* of the Eighty-Third Annual Session of the National Association of Insurance Commissioners, p. 570.

[7] The 1921 Standard Profit Formula stated that "Underwriting profit (or loss) is arrived at by deducting from earned premiums . . . all incurred losses and incurred expenses." See fn. 5.

[8] Fire companies experience a heavier surplus drain from new business since their policies run for longer periods of time, on the average, than casualty policies. They must maintain a pro rata unearned premium reserve liability despite the fact that most of their expenses must be paid immediately.

the NAIC and the states, the 2.5 per cent profit asked by the NBCU appeared just as acceptable.

The question of the proper definition of casualty insurance profits first arose in 1946 with the formation of the *Casualty and Surety Rate Regulatory Bill* as a result of Public Law 15 (McCarran-Ferguson Act). Section (3) of the *Bill* contained this provision:

> (a) All rates shall be made in accordance with the following provisions:
>
> 1. Due consideration shall be given to past and prospective loss experience within and outside this state, to catastrophe hazards, if any, to a reasonable margin for profit* and contingencies, to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, to past and prospective expenses both countrywide and those specially applicable to this state, and to all other relevant factors within and outside this state.
>
> * * *
>
> * The All-Industry Conference Committee believes the word "underwriting" should precede the word "profit." The NAIC is giving further study to this matter.

Most of the states passed the bill verbatim. However, one problem occurred which provoked arguments that lasted until the 1952 NAIC annual meetings. The All-Industry Conference Committees wanted the word "underwriting" placed before "profit and contingencies." The NAIC demurred, and the difference of opinion was never resolved. The matter was subsequently left to the decision of individual states. A 1947 NAIC report summarized the situation this way:

> The primary point at issue is the propriety of including all or part of the investment earnings of an insurance company in the profit factor allowed in the making of rates. The All-Industry Conference Committee, it appears, would restrict the element of profit in rate-making to that derived from insurance underwriting operations, while the Commissioners preferred to re-examine the entire problem. . . .[9]

[9] *Proceedings* of the Seventy-Eighth Annual Session of the National Association of Insurance Commissioners, p. 81.

Eventually forty states inserted the word "underwriting," six did not, and two avoided all mention of any sort of profit.[10]

NAIC Casualty Subcommittee Report

In 1946 the NAIC authorized a special casualty and surety subcommittee to investigate the matter of profit allowance, and in 1951 a special casualty and surety subcommittee was requested for a similar purpose. The primary task of the investigating subcommittee was to a NBCU request for a 5 per cent profit factor in its rate filings for all lines except workmen's compensation. The subcommittee made its report at the Chicago meeting of the commissioners in 1952. A similar committee had been authorized in 1946 to investigate profit allowances for fire and marine companies.

The fundamental premise of the NAIC casualty report is that all sources of income and not underwriting earnings alone should be considered in arriving at the proper profit factor for casualty rates. The subcommittee listed the following factors as being relevant with respect to determining the reasonableness of the profit factor:

(1) The excess of premiums earned over losses and expenses incurred.

(2) All investment income excluding realized and unrealized capital gains and losses.

(3) Income taxes, excluding excess profits taxes.[11]

The subcommittee then added:

> The National Bureau of Casualty Underwriters argues for equal opportunity for the realization of profits as compared

[10] Kulp, *op. cit.*, pp. 576-577. North Carolina and Vermont laws do not mention profit at all, while Florida, Mississippi, New Jersey, New York, Tennessee, and Texas use the word "profit."

[11] *Proceedings* of the Eighty-Third Annual Session of the National Association of Insurance Commissioners, p. 552.

> with the fire insurance business, pointing out that a 5 per cent profit factor is allowed in the fire insurance rate structure. The Sub-Committee agrees that equal opportunity for profit should be given the casualty companies but feels impelled to point out that parity should be determined in relation to the rate of return on stockholders' equity.[12]

The subcommittee felt that stockholders' equity, or the liquidating value of a company, was the proper base against which the reasonableness of profits should be measured. It defined stockholders' equity as ". . . surplus as regards policyholders plus the equity in unearned premium reserve and any equity in the formula loss reserves." [13]

After reviewing the Bureau's filing in light of its own standards and theories, the subcommittee came to the following conclusions:

> . . . an overall profit of 3.5 per cent on premiums will produce on filings made by the National Bureau of Casualty Underwriters a total profit, when considered together with other sources of income, at parity with the result obtained by the inclusion of an allowance of 5 per cent for fire insurance.[14]

The subcommittee stressed that the 3.5 per cent figure was applicable only to the Bureau filing, and it indicated that other filings might require substantially different factors. The subcommittee made no additional provision for a contingency allowance because it felt that contingencies should be taken care of in the pure premium, and any contingencies not covered there bore at the most a "very nebulous" distinction from profits.[15]

The full casualty and surety committee met subsequently and by a tie vote failed to adopt the subcommittee's report. The committee stressed that such action did not constitute either approval or disapproval of the subcommittee's report.[16]

[12] *Ibid.*

[13] *Ibid.*

[14] *Ibid.*

[15] *Ibid.*, pp. 551-553.

[16] *Ibid.*, p. 549.

The Arguments for the Inclusion of Investment Income

In insurance literature there seem to be three distinct types of arguments for the inclusion of investment income (either that portion attributable to policyholders or all investment income)[17] in the definition of casualty profits (realized and unrealized capital gains and losses are usually excluded due to their inherent volatility and unpredictability).[18] The arguments are (1) legal, (2) economic, and (3) regulatory:

(1) *Legal.* Premiums received by insurers belong to the insureds, therefore any earnings realized from the investment of these premiums are the property of the insureds. This argument is neatly refuted by the decision in *National Fire Insurance Company v. Thompson:*[19]

> As soon as a premium is paid and the indemnity is in force, the premium becomes the absolute property of the insurer. It is the price and compensation paid for the indemnity obligation assumed by the insurer. It has been finally earned in every sense of that word by the binding contract obligation to indemnify.
>
> To designate these amounts which must be paid the insured upon cancellation, they are called 'unearned premiums,' while the premiums for the term before cancellation is called 'earned' premiums. Such payment to the insured is not a return, in specie, of any part of the premium paid and the contract for cancellation does not establish any trust or similar relation regarding the premium. It is merely a contract obligation wherein the amount to be paid the insured has relation to and is, in part, measured by the amount of premium paid for the policy.
>
> The company owns the premiums paid by the insured as much as the bank owns the deposit made by its depositors. And the company is no more bound to credit policyholders with the investment returns

[17] While most individuals arguing the affirmative position would only include that portion of investment income attributable to policyholders' funds, a few would consider all investment income in setting profits.

[18] See fn. 4.

[19] 281 U.S. 331, 74 L. Ed. 881 (1930).

on premiums, because it is subject to partial refund upon cancellation (for which contingency the company sets up a reserve), than a bank is obliged to credit depositors with profits made from the investment of deposited funds, because deposits are subject to withdrawal on demand.

(2) *Economic.* Most insurers require that premiums be paid at the start of the policy year[20] although claims will be paid, on the average, at midyear.[21] Delays in claims settlement would increase the average period during which funds can be invested, while delays in the collection of premiums from agents would decrease the period. In any event, the companies have the use of policyholders' funds for a sufficiently long period of time so that they may invest them and realize some return. Some feel that such returns should be taken into account when setting profit allowances in rate structures. Spokesmen for stock insurers hold that stockholders earn this return since their funds are at risk in case of disastrous underwriting or investment experience. This rebuttal is illogical as stockholders already receive earnings from underwriting operations as well as the investment of their capital and surplus equity. On the other hand, those critics of the present profit definition who insist that all sources of investment income be considered in determining profit allowances would seem to be on less solid ground, logically speaking, due to the risk and use elements of the stockholders' investment.[22]

(3) *Regulatory.* This argument is based on the fact that companies are permitted to make rates in concert, thus vitiating the inherent regulatory effects of competition. Prior to this present situation companies competed for stockholders' investments on the basis of total profits, not just underwriting profits. Therefore regulation should be applied to investment income as well as underwriting income.[23] The answers to this argument are two-fold. First, it is pointed out that company investments are regulated, but this is true only to the extent that states restrict company investments, vaguely based on sources of funds, to certain broad categories of security. Second, there is still competition among companies for stockholders' investments based on their investment policies. This seems to be a safe assertion to make since there is no easily ascertainable evidence to refute it (or to support it).

Two points seem unmistakable in the midst of all these controversies: insurance regulatory officials have the right to regulate industry profits, and such profits include investment as well as underwriting sources.

Functions of the Profit Factor

Profits in casualty insurance (and any other insurance area) have two functions:

(1) *Return for risks borne.* Funds invested in the casualty industry are subject to two sets of risks: investment and underwriting. Investment risks (chance of loss of principal and return for the use of the funds) originate not in the casualty industry but in the securities market. The nature of the casualty business will influence the companies' investment policies and thus indirectly influence investment risks, but the securities market is still the fundamental source of risk. Funds invested in the casualty industry must earn a return to compensate for these risks and uncertainties.

[20] Some companies permit policyholders to pay their premiums in installments over the policy year. Most of these companies make a slight extra charge for this deferred payment; a few make no charge at all.

[21] The National Council on Compensation Insurance estimates that the average time between premium collection and disbursement is two-thirds of a year. Schultz, *op. cit.*, p. 86.

[22] See discussion in next section.

[23] Harry J. Solberg, "The Profit Factor in Fire Insurance Rates," *The Journal of Insurance*, November, 1957, pp. 24-33.

Capital invested in the casualty industry is also subject to loss from risks that pertain directly to underwriting. Casualty capital is much like a guarantee fund for the benefit of the policyholders; these funds are needed to satisfy policyholders' claims if premiums prove to be inadequate. Adverse experience can wipe out a company's capital, and in such a case (insolvency) the stockholders are not likely to get back much, if any, of their original investment. Consequently, the investor is entitled to a return for this risk.

(2) *Return for use of capital.* In order for a casualty company to attract additional capital, it may be necessary for it to earn a return for the use of the investor's capital as well as a return for risks to which the capital will be exposed. The supply of and demand for capital will put a value on the use of it for riskless investments. Such a value might be called the pure rate of interest. For a casualty company to acquire additional capital it must be earning (as well as have future prospects for) profits amply large to cover this pure rate of interest plus both types of risks to which it would be subject in this industry.

Conclusions

As was stated by the NAIC casualty subcommittee (and as is apparent in the discussion above), the proper base against which to measure profits is stockholders' equity—this is the amount at risk, not premiums, from the stockholders' standpoint. The return for underwriting risks sustained by stockholders should be a rate allowance, based on stockholders' equity, that permits a commensurate return for the industry (or bureau companies, or whatever the group is). The return for investment risks and the use of capital should be covered by the companies through their individual portfolio policies. The base once again is stockholders' equity, and the rate of return is that rate earned on total admitted assets (since funds from all sources are commingled in asset disposition).

The remainder of the investment income is attributable to policyholders and should in some way be remitted to this group. It is submitted that the simplest way to accomplish this is by means of a premium discount, similar to the approach used by life insurance companies. Competition among companies as well as the size of these earnings and the number of policyholders would determine the size of such discounts, subject to approval by regulatory officials.

The result of these proposals would be several:

(1) Greater rate equity for policyholders. They would receive a return for the use of their funds.

(2) Needed extension of regulatory control into the area of investment income. At present the regulation of profits is incomplete and inadequate.

(3) Pressure on the companies to reduce costs, especially selling expense. With a reduction of investment income companies would have to become more competitive with mutuals and independent or deviating companies in order to attract more business and maintain present levels of profits. An allowance in rates for an underwriting profit is no guarantee that such a profit will be earned—a company must have a sufficient volume of business against which such a factor would apply in order to earn profits. Thus bureau companies would have to meet their competition on the battleline for business and not rely on investment income to carry them.

It is submitted that these results are highly desirable and obtainable if the current philosophy of profit regulation is amended as suggested.

LIFE INSURANCE IN MEXICO

by

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The story of life insurance in the United States is well documented. The Institute of Life Insurance can supply practically any existent information concerning life insurance in this country. There are several excellent textbooks explaining the operation of the life insurance business. Individual life insurance companies, trade associations, and numerous journals and periodicals disseminate widely information concerning the theory, function, and operation of life insurance.

However, if a reader turns to any of the standard American textbooks on life insurance, he is suddenly aware of the fact that none mentions anything about life insurance in Mexico. All of them have a page or two on Canadian life insurance. Otherwise, our books are devoted to life insurance in the United States. Although life insurance is basically the same wherever conducted, there are always differences between the operations in various countries. There has been much recent interest shown in the United States in foreign insurance operations. For this reason, and because of the close proximity of Arizona to Mexico, this research on Mexican life insurance was undertaken.

Statistics on the Mexican Industry

The Republic of Mexico, with an estimated population in 1957 of 31,426,000, has only seventy-one insurance companies of all types domiciled within its borders. Many foreign companies operate in the country but with one exception they are entirely occupied in the business of reinsurance. There is only one company authorized to sell insurance that is not a Mexican company—La Confederación del Canada—which conducts a small life operation as a branch office. However, according to executives of other companies, La Confederación is doing very little direct selling and is primarily a service office for its own policyholders.

Of these seventy-one companies, only twenty-seven are authorized to sell life insurance; and, of those authorized to sell life insurance, only twelve are strictly life insurance companies. The remaining fifteen companies are all-line companies, selling life, health and property insurance. Several executives in Mexico City estimated that of the twenty-seven companies, about six do the majority of the life insurance business in the country. The majority (49) of the insurance companies are domiciled in Mexico City; the remainder are scattered throughout the other states, with no state having more than four companies domiciled in it. In addition to the twelve strictly life insurance companies, there is a firm that does its business solely in the field of life reinsurance. This is Union Reaseguradora Mexicana, S.A., which is jointly owned by about eight or ten of the other life insurance companies in the Republic but does business with all of the companies. Thus, in a country with about one-fifth the population of the

United States, there exist about one-fortieth the number of life insurance companies.

As of December 31, 1958, there were 200,964 policies in force on 196,672 lives. The total amount of individual life insurance in force was 9,679,549,000 pesos ($774,363,900 U.S. currency) [1], from total direct premiums collected of 322,029,642 pesos ($25,762,371). Payments made by life insurance companies in 1958 for death, matured policies et al. amounted to 64,669,000 pesos ($5,173,500). The life insurance business in Mexico saw a considerable increase in every aspect of its operation from 1957 to 1958. For example, the number of individual insureds increased 3.9 per cent, the amount of insurance in force (excluding group) increased 15.6 per cent, the direct premiums collected for individual insurance increased 12.5 per cent, and the number of policies outstanding (excluding group) increased 2.1 per cent. The average amount of life insurance per insured in 1958 was 49,216 pesos ($3,937) and the average amount of insurance per policy was 48,165 pesos ($3,853); however, the average amount of insurance owned per person in the Republic was only 308 pesos ($24). This last figure includes inhabitants of Indian descent. Due to their still-retarded economic position, most companies consider them currently uninsurable. If this racial element (29 per cent of the total) is taken out of the total population figure, the average amount of life insurance per person increases slightly to 433 pesos ($35). This is still a low figure. It points up the tremendous room for expansion of the Mexican industry. Detailed statistics are presented in Table 1.

[1] From this point on, the parenthetical figure will be in U.S. currency, using the exchange ratio of 12.5 to 1.

Company Formation

A review of the requirements for new company formation for life insurers in Mexico is the first step toward explaining why there are so few companies. The Mexican law is rather explicit on the requirements that must be fulfilled prior to entry into the life insurance field. However, explicit as it is in some instances, it is also arbitrary in others.[2]

The minimum required capital is between 2,000,000 and 6,000,000 pesos ($160,000 to $480,000), the exact amount

[2] The source used by the author for the Mexican insurance law was: *Translation of a Compilation of the Mexican Laws on Insurance*, (Mexico, D.F.: Traducciones) mimeographed.

TABLE 1

COMPARATIVE STATISTICS ON MEXICAN LIFE INSURANCE
1957 – 1958

Item	*1957*	*1958*	*Percent Increase*
	Pesos	*Pesos*	
Total Assets	1,125,907,981 (90,072,638)[a]	1,257,300,579 (100,584,046)[a]	11.6
Total Reserves	896,501,992 (71,720,159)	1,007,902,555 (80,632,204)	12.4
Direct Premiums Collected	307,636,325 (24,610,906)	343,553,998 (27,484,319)	11.7
Insurance in Force	9,421,339,000 (753,707,120)	9,693,710,000 (775,496,800)	2.8
Number of Assureds [b]	189,268	196,672	3.9
Number of Policies	196,826	200,964	2.1

[a] Parenthetical figures are in U. S. currency. Ratio used 12.5 to 1.
[b] Excluding group insurance.
Source: *Anuario Estadistico, 1958*, (Mexico: Comisión Nacional de Seguros).

to be determined by the Ministry of Finance and Public Credit.[3] What has happened in practice is that if an existing company—a casualty company, for example—wishes to enter the life insurance field, the Ministry sets the capital requirement at the minimum. However, if a group wants to start an entirely new company with no prior experience in operation, they will be required to supply the maximum capitalization. If a group wishes to start a mutual company (mutual society), then the number of members cannot be less than 300, nor may the sum insured be less than 300,000 pesos ($24,000). Nothing is mentioned in the law about a minimum surplus fund for either mutual or stock companies.

In order to form a new company, authorization must be obtained from the Ministry. Such authorization is discretionary with the Ministry. The application must be accompanied by the proposed constitution of the company plus proof that a deposit equivalent to 10 per cent of the minimum capital has been deposited in Nacional Financiera, S.A. in cash or approved securities. If approved, a copy of the constitution is forwarded to the Public Registry of Commerce to be recorded. Once the company has been recorded and has commenced operations, the deposit mentioned above can be refunded; however, few of the companies have ever taken this refund.

Corporations planning to operate as private companies must be formed according to the provisions of the General Law of Mercantile Companies, on any matters not separately covered by the Insurance Law. It is not necessary to review here the detailed requirements of the Mexican corporate charter; however, a few points of interest might be noted. The company can have an indefinite life, but it cannot have a life of *less* than thirty years. The sole object of the company shall be to function as an insurance and reinsurance company. The constitution must provide that no dividend shall be declared if there are not sufficient funds available to make immediate payment, after having set aside from the profits at least 10 per cent of such profit to set up an ordinary reserve fund. This deduction must be made until the fund reaches a value equal to at least one-half of the paid-up capital. This amount would be termed surplus in the United States. Since mutual companies are of minor import in Mexico, and since no new mutuals are being authorized by the Ministry, the details of their formation are of no current interest.

After the company has complied with the above provisions, and prior to the commencement of operations under the authorization granted, the company will be required to obtain a supplementary permit from the Ministry. This permit will be issued after approval of various documents that are officially submitted, in the Spanish language, by the company. These documents include: specimens of policies, rates for each one of the forms of insurance, the basis for calculating rates, and the tables of guaranteed values under the various plans. The documents, if printed, must be easily legible, and the law goes so far as to give the Ministry the right to fix administratively the typographical requisites for assuring legibility. Once the capital required has been paid in, the permit then will be issued and the company can start operations.

The organization expenses of the new company that can be amortized shall not exceed 25 per cent of the paid-up capital, and such expense must be amortized within a period not exceeding ten years. The law states further that at the end of the sixth year of operations, at least one-fifth of these expenses must be amortized.

Branches of Foreign Companies

If a foreign insurance company wants

[3] Hereinafter referred to simply as the Ministry.

to set up a branch in Mexico, it must fulfill requirements beyond these imposed on domestic firms. In order to obtain authorization from the Ministry, it must prove five years' normal operation. The company must be qualified to operate according to the laws of its country of origin. An attorney-in-fact who is a resident of the Republic must be appointed, and he cannot have any limitations on his powers. The attorney-in-fact, in an application to the Ministry, obligates his principal specifically to be liable, to an *unlimited* extent, with *all* its assets (not only property located in Mexican territory). His company must submit itself exclusively to the jurisdiction of the courts of the Republic in all business transactions effected therein. Thus, a foreign company must be willing to place all of its assets, wherever located, behind any claim.

The foreign company must allocate specifically for its operations in Mexico the minimum capital fixed by the Ministry and must transfer and invest this earmarked capital, capital reserves, undistributed profits, and technical reserves as outlined in the law (see below). Further, the foreign company at all times must keep in the Republic the property, negotiable instruments, credits, and securities representing said capital, profits, and revenues. These, of course, are subject to periodical inspection by the Commission. The foreign company can only publish accounting data referring to its Mexican operations and cannot make any public reference to the capital or reserves of its head office.

In summary, if a life insurance company domiciled in the United States wants to set up a branch in Mexico, it must: appoint an attorney-in-fact with unlimited powers, subject itself to possible liability to the extent of all of its holdings wherever located, and subject itself to the Mexican law. The company must invest all of its branch office capital, surplus, and reserves in Mexican securities (except for 25 per cent of its reserves allowed in foreign investments, a point covered below).

There is only one foreign company actually operating a branch office in Mexico. In order to avoid the stringent requirements imposed, a few companies have set up separate subsidiary operations in Mexico, thereby freeing their own assets from the unlimited liability rule. All that is needed to establish such a corporation is a minimum of five Mexican nationals. The foreign company can then either buy all or a majority of the outstanding stock in the company in order to control it. This has been done in four or five cases that have been brought to the attention of the author.

Mexico has not approved the entry as a foreign company of any United States insurance company in recent years.

Investments

Mexican insurance law outlines in great detail the types of securities in which funds must be invested, even to the extent of certain percentages for various types of investments. Various states in the United States also use this so-called "legal list" approach for investments whereby only certain types of securities are legal, however, usually in only two cases—common stock and real estate—are there any limitations as to how much (percentagewise) can be invested in specified types of investment.

The investment regulations apply to the paid-up capital, capital reserves, undistributed profits, and technical reserves. These funds totalled 1,138,159,810 pesos ($91,052,784) in 1958. A partial summary of the legal list of investments is as follows:

1. Shares of other insurance companies, never exceeding 20 per cent of the paid-up capital and capital reserves of the investing company, and in no case to

exceed 40 per cent of the capital of the issuing company.

2. Shares of companies exclusively in the reinsurance field, the maximum percentage to be fixed by the Ministry.

3. Investments abroad that may be necessary, after authorization from the Ministry. These may reach 25 per cent of the surplus over the minimum capital, but only so long as the company issuing the purchased security has actual investments in Mexico.

These first three types of securities, and their respective percentages, apply just to the investment of capital. The remaining apply to both capital and reserves.

4. Bonds or securities issued by the Federal Government, the Government of the Federal District and by national credit institutions, as well as securities issued by Federal de-centralized public organizations approved for the purpose by the National Securities Commission.

5. Mortgage indenture bonds and certificates, issued or guaranteed by duly authorized credit institutions.

6. Shares and bonds of Mexican companies other than mining, petroleum, or insurance companies (see paragraph 1 above for permitted investment of capital in insurance company stock), approved for such purpose by the National Securities Commission by general rulings.

7. Loans secured by the pledge of the shares, bonds, or securities mentioned in 4, 5, and 6 above. The amount of the loan shall not exceed 80 per cent of the value of the pledge.

8. Loans guaranteed with the mean premium reserves, provided the amount of the loan does not exceed the corresponding terminal reserve.

9. Mortgage loans on urban real estate which, in the opinion of the National Insurance Commission, produce regular proceeds for a term not exceeding ten years, provided the amount of the loan does not exceed 50 per cent of the total value of the real estate representing the mortgage guarantee or 30 per cent of its value in the case of specialized real property. For mortgage loans on urban property intended for homes which fulfill the characteristics fixed by the Ministry for administrative process, the amortization period shall not exceed fifteen years, nor may the amount of the loan exceed 65 per cent of the value of the property. Mortgage loans must be secured by a first mortgage and must be repaid by equal periodical payments. The real estate must be insured against fire, explosion, and earthquake for its destructible value.

10. Urban real estate, located in the Republic, which produces regular returns; with such property insured against fire, explosion, and earthquake for its destructible value.

11. Participation certificates secured by the pledge of real property. The trust contracts must be submitted for approval to the National Insurance Commission, and such certificates shall be computed as investments in real estate.

12. Sight deposits in legally-authorized credit institutions.

The law then specifies certain percentage requirements for the above investments. For example, at least 25 per cent of the technical reserves, paid-up capital, and capital reserves must be invested specifically in participation certificates or mortgage bonds of national credit institutions, in series bonds of the Federal Government or of the Federal District, issued for public service works and guaranteed by setting aside, in trust, of the proceeds from some tax, service charge or revenue which, in the opinion of the Ministry, suffices to meet the interest and amortization service. The trust in favor of the bondholders in these cases must be set up in some national credit institution; or an irrevocable power-of-attorney must be executed in the name of the common

representative of the bondholders, enabling him to collect the interest or revenue in question. Such securities shall be issued with interest not exceeding 6 per cent per annum. Further, 10 per cent of such funds must be invested in low-cost housing or national government housing bonds. As another example of the strict limitations imposed on the investments of the life insurance companies, they may keep no more than 10 per cent of their total assets in cash and in sight bank deposits. This latter restriction has been interpreted to mean that the cash can be no more than 10 per cent of total assets as of December 31 of the year in question. Therefore, a company could possibly have all of its assets in cash throughout the year, if on December 31 cash is reduced to the indicated percentage. This actually is a rather high allowance, as all companies try to invest their money immediately so that it will begin to earn a return. There are numerous other percentage limitations, too detailed for review within the limitations of this paper.

There is, however, one other limitation that is of interest, particularly for subsidiaries of companies domiciled in the United States or other foreign countries. The Ministry can authorize insurance companies to invest in foreign currency securities the reserves corresponding to their obligations in foreign currency, but these shall in no case exceed 25 per cent of the total reserves. When the reserves of life companies corresponding to their obligations in foreign currencies reach this mark, they may in effect no longer issue policies in foreign currencies. It should be noted that United States dollar currency investments are regularly available in Mexico.

Another section of the law pertaining to investments may appear to be rather unusual, especially in light of practices in the United States. The law requires that the shares, bonds or securities forming the reserves as outlined in the law must be physically deposited in the Nacional Financiera S.A., and cash must be deposited in the Banco de Mexico. These investments shall be set aside for the fulfillment of the company's obligations in the respective operation or branch of insurance. In this way the government is guaranteed that the reserves cannot be wrongfully dissipated in any way except through economic changes that may affect values. Table 2 presents a break-down of the specified reserve investments of Mexican life insurance companies as of the end of 1958, and Table 3 presents the break-down of the investments of total assets.

There are several items that should be noted in Tables 2 and 3. The first three items appearing in Table 2 after the Total are those types of investments that must equal at least 25 per cent of reserves. In 1958, these investments totalled 25.97 per cent, which is typical of the fact that they always stand near the required figure. The amount of policy loans appearing in Table 3 in interesting. Due to the relatively high interest rates available from private investment (8 to 12 per cent) and the relatively low guaranteed interest rate on the policy loans (4½ per cent), most policyholders borrow the loan values and invest it privately. According to at least one informant, earnings on such investments by borrowers are enough not only to pay the interest on the loan, but the premiums as well. So it is unusual to find a policyholder in Mexico who has not borrowed the majority of his policy loan value.

Reserves

What is meant by the technical reserves mentioned earlier, and what is the basis for their establishment? The law specifies the following technical reserves:

1. Reserves for current risks under policies in force (mathematical reserve).

TABLE 2

TECHNICAL RESERVE INVESTMENTS OF ALL MEXICAN LIFE COMPANIES
1958

Item	*Amount*	%
	Pesos	
TOTAL	1,054,255,164 (84,340,400)[a]	100.0
Securities issued by the Federal Government	38,629,934 (3,090,394)	3.66
Securities issued by national credit institutions	214,176,636 (17,134,130)	20.31
Shares of credit institutions	21,096,100 (1,687,688)	2.00
Mortgage certificates	8,283,800 (622,704)	0.78
Mortgage bonds	1,334,164 (106,733)	0.13
Financial and general bonds	3,334,223 (266,737)	0.32
Industrial mortgage obligations	33,824,322 (2,705,945)	3.21
Industrial shares	22,119,396 (1,769,551)	2.10
Other securities	3,652,988 (292,239)	0.35
Land or real estate	308,421,622 (24,673,729)	29.25
Mortgage loans	114,150,260 (9,132,020)	10.83
Loans on policies	202,589,428 (16,207,154)	19.22
Guaranteed loans	43,841,834 (3,507,346)	4.16
Reserves with authorized reinsurers	13,317,343 (1,065,387)	1.26
Past due premiums	18,843,993 (1,507,519)	1.79
Other investments	6,639,121 (531,129)	0.63

[a] Parenthetical figures are U. S. currency with ratio of 12.5 to 1.
Source: *Anuario Estadistico, 1958*, (Mexico: Comisión Nacional de Seguros).

2. Reserves for unfulfilled liabilities under matured policies, for losses incurred and unpaid, and for dividends on deposit.

3. Contingent reserves to cover fluctuations in securities and variations in statistical estimates (the Prevision).

Reserves for current risks are developed as follows:

1. The mean reserve for premiums corresponding to policies in force at the time of valuation, deducted from the deferred net premiums for insurances on which the premium remains constant and the probability of loss increases with time.

2. That part of the tariff premiums unearned at the date of valuation for temporary renewable insurances, within the period of each year in which it is in force and for life insurance.

This mean reserve shall be calculated each year on all policies, and shall be based on American Experience Table of mortality (or a table giving a value equal to or greater than that obtained from this table) at a rate of interest not to exceed 4½ per cent per annum. For the valuation of industrial life insurance policies (of which there are practically none), the table to be used by the companies shall be the Standard Industrial Mortality Table (or a table that will give a greater reserve) at a maximum rate of interest of 4½ per cent. The method of calcu-

TABLE 3

SUMMARY OF ACTIVE BALANCES
(Assets)
1958

Item	*Amount*	%
	Pesos	
TOTAL	1,257,300,579 (100,584,046)[a]	100.0
Real Estate	297,310,512 (23,784,840)	23.6
Mortgage Loans	116,982,716 (9,358,617)	9.3
Other Investments	7,571,424 (605,713)	0.6
Loans with Pledged Security	50,144,562 (4,011,564)	4.0
Loans with Guaranteed Policies	202,589,428 (16,207,154)	16.1
Stocks and Bonds	439,418,096 (35,153,447)	34.9
Cash and Bank Deposits	19,467,685 (1,557,414)	1.5
Other Institutions	44,831,037 (3,586,482)	3.6
Debtors	55,188,892 (4,415,111)	4.4
Branches	59,721 (4,777)	0.1
Furniture and Appliances	10,345,912 (827,672)	0.8
Organizational Expenses	386,270 (30,901)	0.1
Other Assets	10,336,658 (826,932)	0.8
Deficits of Preceding Years	781,740 (62,539)	0.1
Losses from Operations (by some companies)	1,885,926 (150,874)	0.1

[a] Parenthetical figures are U. S. currency with ratio of 12.5 to 1.
Source: *Anuario Estadistico, 1958,* (Mexico: Comisión Nacional de Seguros).

lation of these mean reserves shall be according to the full net premium valuation method; however, if a company desires, it may deduct from the mean reserve thus calculated the present value of the annual amortization which is provided in the tariff premium to cover the initial expenses of acquiring the insurance. The maximum period for the amortization of the expenses of acquisition shall be the duration of the contract. It is further provided that the expenses of acquisition must be contained in the tariff premium and may never exceed the percentage of said premium which the Ministry may fix for each plan. Based on the 1958 figures, the expenses of acquisition as a percentage of direct premiums collected amounted to slightly under 20 per cent. In any event, the mean reserve cannot be less than the amount resulting from the application of the full preliminary term method.

The second reserve, that for unfulfilled obligations covering matured policies and for losses incurred but unpaid, shall be equal to the total amount of the sums which the company is obligated to pay due to an event which has occurred but for which no funds have been paid out. The reserve for dividends left on deposit shall be calculated taking into account the accrued interest up to the date of valuation.

The third reserve required by law is the Prevision Reserve (contingency). This

reserve shall be set up with 1 per cent of the premiums charged during the year, after deducting those ceded for reinsurance. However, if 10 per cent of the net profits shown on the Profit and Loss Statement exceeds this 1 per cent, the company must alternatively set aside precisely such 10 per cent of the profits to form the Prevision Reserve. If this is done, the company cannot deduct on its Profit and Loss Statement the alternative of 1 per cent of premiums collected. Furthermore, this reserve must be increased each year until it reaches a value equal to 10 per cent of the mean reserves for premiums, plus 25 per cent of the annual tariff premiums on one year Renewable Term insurance policies (mainly group insurance) in force at the date of the valuation. This reserve can only be touched in the cases provided by law, and its must be continually accumulated as long as it is less than 10 per cent of the mean reserves for premiums.

For reinsurance operations effected with either authorized or unauthorized companies, the law requires the ceding authorized company to retain and invest, in Mexico, the first two reserves mentioned above. This would ordinarily not be unusual for cases where reinsurance is transacted with an unauthorized company, but it does appear to be very unusual for cases where the reinsurance is ceded to an authorized insurer. One of the well-known reasons in the United States for reinsuring on a co-insurance basis is to relieve the direct-writing company of the obligation of setting up reserves on that portion of the business that is reinsured, which relieves the strain on surplus. This is not true in Mexico, particularly since all reinsurance is done on a yearly renewable term basis.

One other reserve that is required, though not a part of the technical reserves, is the capital reserve (Reservas del Capital). This reserve appears to be the closest thing to surplus known to the Mexican insurance industry. This reserve is very simple to calculate—10 per cent of profits, if any. At the end of 1958, this reserve was 53,257,255 pesos ($4,260,580). This was 5.2 per cent of the technical reserves.

Policy Provisions

The law has, as would be expected, certain mandatory clauses to be included in the life insurance policy. Any policy covering a person under twelve years of age or a person of unsound mind shall be null and void. The company is bound to refund the premiums less the amount it is entitled to for expenses if it acted in good faith. This is a little stronger than the prevailing rule in the United States —that a life insurance contract on a minor child (as defined by state law) is a voidable contract; and, if the minor elects to void the contract, the *entire* premium is refunded. The provision of the law with respect to misstatement of age is similar to that found in the United States. There is also a suicide clause which calls for full payment of the policy if the suicide takes place after two years from the policy issuance; however, if the suicide is before two years, the company shall return not the premiums paid, but the mathematical reserve. Though the law does not require the contract to contain an incontestability clause, all of the companies have seen fit to put one into their contracts. Also, practically all new policies now being issued have an automatic premium loan provision.

A new company, in applying for a supplementary permit prior to starting its operation, must submit various papers and documents, including tables of guaranteed values (non-forfeiture values). As do the laws of the various states in the United States, Mexican law requires each life insurance policy to have included in it a table of guaranteed values which must commence after the annual policy premi-

um has been paid for three years. These guaranteed values are the same as our non-forfeiture values; and there are the usual cash value, extended term insurance, and paid-up insurance options. These values must be at least equal to three-fourths of the corresponding terminal reserve. In effect, then, what is specified is a surrender charge equal to at least 25 per cent of the reserve. This contrasts with computing guaranteed values on the Adjusted Premium Basis, as has been applicable in the United States since the Guertin legislation of 1948.

There is one important peculiarity in the Mexican Insurance Law pertaining to life insurance that has caused a great assortment of policies to be issued. Under the practice established by the Commission, once a company has established a rate for a particular type of policy and filed it with the Ministry or Commission, no other company can charge a lower rate for this same policy. What has happened as a result is that many special and unique combination policies are issued which combine endowments, pure endowments, and various types of term insurance into one policy. There are very few continuous premium whole life policies being issued, primarily due to the fact that the premium for this type of policy was filed years ago. With better mortality and interest, as well as lower expenses, the companies are able to offer unusual combination policies with higher benefits at lower effective rates than the "established" life policy rate.

Group Life Insurance

There is one relatively new field in the Mexican life insurance industry—that of group life insurance. The law provides that if the insurance is to apply to the entire group (100 per cent participation), the group must consist of at least 25 people; however, if the insurance applies on only 75 per cent of the insurable group, such percentage shall never represent less than 50 people.

Insurable groups, according to the law, are:

1. Employees or workers of the same employer or company.
2. Syndicates or unions of workers who are fully employed.
3. Unions of Popular Credit.
4. Army, Police and Firemen's Corps.
5. Other groups duly formed which, on account of the work or occupation of their members, represent insurable groups, in the opinion of the Ministry.

If the group insurance is to be written on a contributory basis for employees of the same company or employer, they cannot contribute more per member than one peso per month per one thousand pesos of insurance. This means, of course, that the amount of contribution by labor is rather high when the peso is converted to U.S. currency—a maximum of 8¢ per month per $80 of insurance, or $1 per month per $1,000 of insurance. In the United States the generally accepted standard for contribution is 60¢ per month per thousand dollars of insurance. It should be noted, however, that most of the group life insurance contracts being written are on a non-contributory basis.

The group life insurance policies have a conversion privilege similar to that found in the United States—conversion to any standard policy except term insurance within thirty days of termination without a medical examination and with the rates prevailing at the attained age. Some statistics on group life insurance are presented in Table 4.

Some interesting developments and trends can be ascertained from the information presented in Table 4. For example, whereas the amount of group life insurance in force in 1958 represented a gain of 22.5 per cent over that in 1957, group life insurance in the United States only increased 14 per cent from 1956 to 1957.[4]

[4] *Life Insurance Fact Book, 1958*, New York: Institute of Life Insurance, p. 26.

TABLE 4

POLICIES, CERTIFICATES, AND SUMS INSURED
GROUP LIFE INSURANCE
DECEMBER 31

Year	*Number of Outstanding Policies*	*Number of Certificates*	*Sum Assured*[1]
			Pesos
1950	197	116,301	392,973 (31,438)[a]
1951	227	132,529	480,962 (38,477)
1952	219	138,205	653,102 (52,248)
1953	227	144,240	681,867 (54,549)
1954	256	153,875	784,728 (62,778)
1955	275	162,343	875,851 (70,068)
1956	298	163,602	929,105 (74,328)
1957	323	170,963	1,052,209 (84,177)
1958	343	198,516	1,289,822 (103,185)

[1] 000 omitted.

[a] Parenthetical figures are U. S. currency with ratio of 12.5 to 1.

Source: *Anuario Estadistico, 1958,* (Mexico: Comisión Nacional de Seguros).

The increase during the same period of the number of policies was 6.2 per cent and for the number of certificates 16.1 per cent. Comparing 1950 with 1958 also shows the trend in the growth of group life insurance in Mexico. In the eight year period, the number of policies increased 74.1 per cent, the number of certificates 70.7 per cent, and the sum insured 228.2 per cent. The average amount of insurance per certificate in 1958 was 6,497 pesos ($519), whereas it was only 3,379 pesos ($270) in 1950—an increase of 92.3 per cent. So, not only is the number of policies increasing, but the average amount of group insurance per employee is increasing at an even faster rate. Although there are some group permanent plans in existence in the United States, group life insurance in Mexico is entirely written on a one year renewable term basis.

Underwriting

The medical director of one of the largest life companies was interviewed by the author. His comments will be used as the basis for most of the following brief discussion.

Both medical and non-medical insurance are written. In the company studied, policies will be issued up to 30,000 pesos on a non-medical basis for lives to age 45. In cases that are on a medical basis, the applicant must be examined by a *company-approved doctor;* and, if the amount of insurance applied for is over 500,000 pesos, two medical examinations plus a chest X-ray and an electrocardiogram will be required. There is an organization in Mexico similar to the Medical Information Bureau (MIB) in the United States, known as the Oficina Informadora de Impedimentos. Inasmuch as many of the companies reinsure through the same company (Union Reaseguradora Mexicana, S.A.), underwriting procedures tend to be very much alike.

The main physical problems encountered in underwriting are, in order of importance, high blood pressure, diabetes, heart diseases, and digestive disorders.

Table 5 presents the number and causes of death in 1958. Table 6 shows the distribution of deaths by cause for selected years.

TABLE 5

DISTRIBUTION OF DEATHS BY CAUSE
INDIVIDUAL LIFE INSURANCE
1958

Cause of Death	*Number*	*%*
TOTAL	1190	100.00
1. Infectious and parasitical diseases	22	1.85
2. Cancer and other tumors	164	13.78
3. Rheumatic, nutritional and endocrine gland diseases and other related maladies	47	3.95
4. Chronic intoxications and poisonous illnesses	27	2.27
5. Illnesses of the nervous system and sense organs	92	7.73
6. Illnesses of the circulatory system	388	32.60
7. Illnesses of the respiratory system (not designated) as tuberculosis	72	6.05
8. Illnesses of the digestive tract	118	9.92
9 Diseases of the urinary and genital tract (no afterbirth or venereal diseases)	53	4.45
10. Pregnancy, birth and afterbirth infections	....	.....
11. Skin, cell tissue and locomotion impairment	....	.....
12. Defects of congenital conformation	10	0.84
13. Old age and senility	4	0.34
14. Violent and accidental deaths	174	14.62
15. Indeterminate causes of defunction	19	1.60

Source: *Anuario Estadistico, 1958,* (Mexico: Comisión Nacional de Seguros).

TABLE 6

DISTRIBUTION OF DEATHS BY CAUSE
INDIVIDUAL LIFE INSURANCE
SELECTED YEARS

Cause of Death	*Number of Deaths*		
	1948	*1953*	*1958*
TOTAL	1,444	1,270	1,190
Infectious and parasitical diseases	147	58	22
Cancer and other tumors	164	148	164
Illnesses of the circulatory system	325	334	388
Illness of the digestive system	218	159	118
Violent and accidental deaths	200	192	174
Other illnesses	390	379	324

Source: *Anuario Estadistico, 1958,* (Mexico: Comisión Nacional de Seguros).

The death rate per 1,000 insured lives in 1958 was 6.05, which compares favorably with the 8.334 rate in 1948. This decrease of 27.4 per cent is a result of a combination of factors, principally the increase in the number of insured people plus a decrease in the number of deaths of insured lives. The number of infections and parasitical disease deaths, which are primarily caused by poor sanitation and preventable by public health measures, dropped from 147 to 22, a decrease of 85.1 per cent. However, in the same period, deaths from cancer and other tumors showed no change; and deaths from illnesses of the circulatory system increased 19.3 per cent. Violent and accidental deaths decreased 13 per cent, and deaths from illnesses of the digestive system decreased 45.9 per cent.

Marketing

The marketing of life insurance in Mexico is another important area for comparison with methods in the United States.

All agents must be licensed by the regulatory officials, the National Insurance Commission. There is no examination or charge for this license. Practically anyone who is not obviously in a position to be able to bring pressure on people to buy insurance from him can become an agent if he can get a company to appoint him and if he can obtain the approval of the Commission. According to most of the executives interviewed, about three-fourth of all the agents in the Republic are part-time, which may account in large measure for the relatively small amount of insurance in force. These same executives stated that life insurance selling techniques seem to be about ten years behind those currently used in the United States.

The National Insurance Commission fixes the maximum commissions permissible for agents of a company. This limit may be higher for the first three years of operation of the company. The commissions generally run rather high—as much as 110 per cent of the premium in some companies—and it is not unusual to find companies paying as much as 85 per cent, though most of this high commission is paid as a bonus rather than as a commission.

One practice that is rather prevalent in Mexico is that of rebating. It was stated by respondents that many of the insureds expect a rebate and go so far as to use the amount of rebate as the basis for deciding which agent to patronize. Notwithstanding this practice, there is in the General Law of Insurance Companies an article that states that no company or agent shall grant an insured a reduction in premiums or any other advantage not specified in the policy. Though everyone knows the practice of rebating premiums exists, it is a practice that is practically impossible to prove legally. Another practice that is widely followed is that of twisting; however, it is not the usual form of "twisting" with which we are familiar in the United States.[5] This is twisting within the same company, though the other type goes on also.

A sample marketing organization of one of the oldest life insurance companies in the Republic can be described. In that company, a supervisor, (who would compare to the general agent or branch manager of United States firms) has charge of a particular state. He will have special agents (who would correspond to what we know as a district manager) in charge of either a city or a section of a state. The agents then operate out of the special agent's office. None of these men is given a salary. Each works on a commission, with the supervisor averaging 12 per cent, the special agent averaging 5 per cent, and the agent averaging 50 per cent of first year premiums on policies written. Training agents is the task of the supervisor, this effort usually lasting about one month in the supervisor's office. In the process of selection of new agents, this company makes use of the Life Insurance Agency Management Association (LIAMA) aptitude index, as modified for Mexico, as well as a commercial report on the individual.

Regulation

Many regulations apply to the insurance industry as a whole. Over-all regulation is in the hands of the Ministry of Finance and Public Credit; however, much of the detailed day-to-day regulatory work is carried out by the Comisión Nacional de Seguros (National Insurance Commission). It is a federal regulatory body; and the individual states, contrary to the method of regulation in the United States, have nothing to do with insurance regulation.

The Comisión is governed by a Board of seven members, five of whom are

[5] In the United States, twisting usually means inducing a policyholder to lapse or cancel a policy in one company for the purpose of replacing such policy in another company to the detriment of the policyholder.

assigned by the Ministry and two by the insurance companies. It should be noted that the two men who represent the industry on the Board cannot attend a meeting or vote on any matter pertaining to any company; however, they do attend meetings and vote on any matter of general interest to the industry. The operating head of the Comisión is the President, who is also appointed by the Ministry. There are in the organization of the Comisión what could be called five line departments and three staff sections. The departments and sections and their functions are:

1. *Inspection Department*—This department inspects the accounting records of the companies; checks the income tax paid; and, a very interesting function, approves all company advertising. This last function is designed to prohibit false and misleading advertising. Every advertisement of any type (even blotters and book matches) which contains the company's name must have the approval of this department. At the bottom of every advertisement one will see a notation, such as "Pub. Aut. C.N.S. en Of 927 d 11-1-58," which shows that the advertisement was authorized by the Comisión.

2. *Actuarial Department*—This department checks the rates and reserves of all companies, as well as the reinsurance contracts.

3. *Legal Department*—This department handles complaints, checks contracts, and authorizes agents and agency contracts. In regard to complaints, the section can be named the arbitrator by both parties concerned; however, if this is done, the ruling of this department cannot be appealed to the courts. If it is not named arbitrator, court action can be used.

4. *Investment Department*—This department publishes monthly a list of authorized common stocks; and, if a company holds any common stock not on this list, it must be sold. It also authorizes the other investments of the companies.

5. *Administration Department* — This department has the duty of managing the internal operations of the Comisión itself.

6. *Valuation and Engineering Section*—This section works closely with the Inspection and Investment Departments. Its principal function is to check the valuation of real estate included in investments to be sure that company's valuation is correct and valid.

7. *Statistical Section*—This staff section furnishes statistics to any of the other Departments.

8. *Agricultural Section*—This section is advisory to the departments in regard to matters pertaining to agriculture, this being the newest form of insurance in Mexico.

The Comisión Nacional de Seguros receives it entire financial support from the insurance companies it regulates. Every company has levied against it an amount that is determined by the budget of the Comisión. Insofar as these levies are concerned, the budget of the Comisión is allocated into three sections: 50 per cent of the budget comes from a levy on the companies based on capital; 30 per cent of the budget comes from a levy on premium volume; and 20 per cent comes from a levy based on profits. Within these three sections, each company is assessed on a proportionate basis.

Conclusion

This report is not meant to be a exhaustive study of the life insurance industry in Mexico. It has tried to present in a concise manner some of the outstanding features of the business. Life insurance is clearly a growing field in Mexico. With a population of over 31,000,000 people and only slightly more than 200,000 lives insured in Mexican companies, the potential is tremendous. The principal obstacle to growth, apparently, lies in the agency system. With about three-fourths of all

agents being part-time, they are selling principally to their friends and relatives. Organization of life underwriters associations would help to raise the level of agent skill and drive; ultimately, such movements as the Life Underwriter Training Council (L.U.T.C.) and Chartered Life Underwriter (C.L.U.) would be of tremendous value to the industry. This may be in the distant future, but it is bound to happen as the industry grows and as the needs of the population become more complex, demanding better trained and better qualified agents. According to most of the executives interviewed, one of the most important problems agencywise is that of pirating of business by agents in the United States. The Mexican law forbids any insurance contracts to be sold in Mexico except by Mexican companies. As a result, many agents in the United States bring Mexican citizens across the border and write the life insurance policy in the United States. This is definitely not a healthy situation, especially when viewed from the eyes of a Mexican insurance man. What can be done to prevent the practice is not clear at the present time, but the situation is being studied closely. Due to a higher mortality rate in Mexico, policies of Mexican companies that are predominantly protection-type policies cost more than those of companies domiciled in the United States. On the other hand, due to the higher guaranteed interest on Mexican policies, their investment-type policies cost less than similar policies issued by companies domiciled in the United States.

Mexican law is a great deal stricter than regulation in the United States, except perhaps for a very few highly-regulated states. Nevertheless, though the law is stringent, the real problem is enforcement. Many things forbidden by the law are actively carried out in the country since they are next to impossible to prove, especially the practice of rebating. This is a problem best solved by each company policing its own agency ranks. Such policing is now being undertaken by a few companies; but until the entire industry does so, the practice will undoubtedly continue.

Most individuals interviewed agreed that only the highest income group in Mexico now buys life insurance. This could be ascribed to the extensive social insurance program in the country. This factor is discounted by most insurance men because the benefits provided are very small. The major reason for the low amount of life insurance in force is clearly the relatively poor economic position of the majority of the citizens of Mexico. Many analyses have been written in recent years about the emerging middle class of Mexico. This may be the key to the future growth of the life insurance business in Mexico. New members of this middle class are much better educated than their parents. They are earning higher wages and salaries. They should be more prone to listen to an agent when he presents the advantages of life insurance for the protection of a family. All that can be concluded with certainty is that there is a tremendously bright long-run outlook for life insurance in Mexico.

INSURANCE IN CZECHOSLOVAKIA

JAROSLAV PROCHÁZKA

In Czechoslovakia there is only one insurance organization, the "Státní pojišťovna," which has the right to carry on the business of life and property insurance. This Institute is an independent juristical person and forms a part of the Czechoslovak financial system.

The Státní pojišťovna is managed by a General Management, and it organs are the Branch Office for Slovakia, the district agencies for various districts, and regional agencies. By this arrangement a consistent decentralization of insurance operation into the districts and regions has been effected. The activity of the Státní pojišťovna has been linked with the State Economic Plan, and the insurance service is organized in such a way as to serve in the best way possible the interests of the Czechoslovak economic development and all Czechoslovak citizens.

The Státní pojišťovna is managed and represented by the General Manager, who is nominated and recalled by the Minister of Finance. The General Management organizes, directs, and controls the activity of the Státní pojišťovna throughout the whole territory of the Czechoslovak Republic. In Slovakia this activity is carried on by the Branch Office for Slovakia in accordance with the instructions issued by the General Management.

The task of the Státní pojišťovna is as follows:

1. To insure personal and property interests of the working people
2. To insure agricultural production and thus to contribute to the safeguarding of the socialist ownership of collective farms as well as the personal property of the collective farmers
3. To insure national property in such cases where this is expedient and suitable from political and economic reasons.
4. To take part in loss prevention
5. To contribute to the socialist accummulation fund by concentrating financial means

Thus, the task of the Státní pojišťovna is to help in the construction of the national economy and to contribute to the continuous increase of the well-being of the working people.

The Státní pojišťovna underwrites all classes of insurance—life and non-life. In all branches in which the Státní pojišťovna is underwriting, the extent of its liabilities has been considerably widened. Important reductions in rates have been effected so that they now compare with the prewar period. New forms of comprehensive covers have been introduced in property and life insurance, and in one insurance policy many different risks have been embodied. This naturally makes possible the reduction of rates.

In property insurance the householder's policy comprises 15 different classes of risks and the Státní pojišťovna indemnifies against losses caused by fire; explosion; lightning; storm and tempest; falling of trees, masts, and similar objects; floods and similar risks; hail; losses caused by weight of snow, landslide, and rockslide; burglary, waterpipes damage; and third party insurance of husband and wife insured as private householders. Similar risks are covered by comprehensive policies on

buildings. Agricultural group policies now cover the farmers against fire, hail, live stock death, burglary, accident, and third party liability; and these risks are covered by a single policy, as compared with 7 policies formerly required for such coverage.

Comprehensive insurance brought to the assured not only simplification in its relation to the Státní pojištovna and reduction in rates; but, above all, it widened insurance protection to include many risks which, before, were not covered or were not insurable.

The property of collective farms is covered by the Státní pojištovna on the basis of property statements. These are prepared and made out by the farm management according to its books and ledgers. They also compute the premium. No insurance policies are issued.

In 1951, new regulations were issued in respect of the third party motor insurance. According to these regulations each person responsible for the operation of a motor vehicle is covered by compulsory insurance. It is not necessary to effect an individual policy. Every one sustaining a loss by a motor vehicle may claim an indemnity regardless of whether the offender is identified or not. The premium for this insurance is much lower than was motor insurance in the pre-war period.

A new form of personal insurance has been introduced by the Státní pojištovna for the working people. This is generally effected in the factories, collective farms, and different organizations. It is a special form of insurance, providing for endowments and death coverage; and health insurance is included. This is offered to members of the collective farms through a special comprehensive life and health insurance contract; and the premium is paid through the collective.

In addition to the above comprehensive insurances the Státní pojištovna effects also individual fire and health insurances of all classes of business. The health insurance covers losses caused by accident and also the damage to health of the assured caused by poisoning by foodstuffs and drinks; losses caused by infection due to the penetration of morbid germs into a wound caused by accident; further poliomyelitis anterior acuta; and encephalitis. This personal accident insurance is thus giving a wide cover outside the scope of the social health insurance granted from public funds.

In addition to its insurance activity, the Státní pojištovna participates in organizing and effecting various measures to prevent the appearance of losses or to diminish the consequences of the losses occurred. This activity is directed primarily to fighting fire losses and losses of live stock. In the transport sphere it concentrates on road security and on the prevention of losses caused by accidents. To assist in this activity, the organs of the Státní pojištovna conduct fire inspections to ascertain whether the insured property is properly safeguarded. Further, it is educating the public to protect public and personal property. In order to promote fire prevention, the development of live stock breeding, and the limitation of losses in the live stock industry, the Státní pojištovna grants under certain conditions premium discounts. Thus, it is contributing financially to prevention measures against such losses.

Foreign insurance is handled by a special Foreign Department of the Státní pojištovna, controlled by the General Management. This Foreign Department handles insurance of export and import transport. Further, it is responsible for all reinsurance and retrocession business, whether inward or outward, of all branches of the insurance business. It also effects co-insurance with foreign insurance companies and the placement of special risks. The insurance conditions for foreign transport business provide very broad

coverage for all classes of transport. The loss prevention activity of the Státní pojištovna in this class of business is directed especially in tracing the defects in the quality of goods, their packing, and the means of conveyance. Thus the Státní pojištovna contributes systematically to the improvement and security of the country's foreign business.

To be able to fulfill properly its task in harmony with the interests of Czechoslovak economy and with the interests of the working people, the Státní pojištovna is working in close co-operation with the National Committees of the towns and villages which help the Státní pojištovna, especially in the field of fire prevention. The Státní pojištovna cooperates also with other state and voluntary organizations.

The Státní pojištovna is conducted in harmony with the all-state economic plan, the spirit of which is the greatest economy in the operation of business and constant widening, improving, and cheapening of insurance protection. The number of policies and premium volume are constantly increasing in both the property and personal lines of insurance. This is evidence that the standard of life of the citizens of the Czechoslovak Republic is continuously improving.

THE AGENT'S RESPONSIBILITY FOR DEVELOPING SOUND INSURANCE PROGRAMS

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People have not always been fully cognizant of the importance of a good insurance program and the effect it has on a firm's operating costs or on the financial status of an individual. The result was that many firms which suffered unusual losses, or losses where coinsurance clauses were used, found themselves inadequately covered. Today there is an increasing awareness by top management in industry, as well as by the average policyholder, of a need for a sound insurance program.

What are many of the large firms doing about this situation? They are employing trained personnel as supervisors of the insurance accounts. The insurance manager or supervisor performs the same function as a buyer in any other part of the firm, e.g., the purchasing agent for raw materials. He renders an informed opinion on the insurance needs of the company. Although all firms can not afford this staff position, it is possible to secure this service from independent insurance consultants. This is where agents can make valuable use of their insurance talents by not only acting as salesmen but also as advisors to their policyholders. In either case, whether a firm secures this service from an outsider or from a member of its own staff, proper protection can be secured by the application of the fundamental principles of insurance selling. Insurance agents should recognize these principles, but it is always a good idea to review them frequently.

How many agents have failed to survey their policyholders needs? If they reviewed their records, there would be many illustrative cases. This situation often exists because they do not write all of the insurance coverage owned by a given policyholder. There are agents who have gotten their start in the property and casualty insurance business by surveying the needs of prospective policyholders and comparing these needs with the present insurance coverages carried. These studies uncover some interesting errors in coverage. For example, it was found that the president of one large lumber company was insured under a workmen's compensation policy as a yard hand, instead of as an office worker, which he had become as president of the firm. In this same firm, delivery trucks were being insured individually for ten, twenty and five thousand dollars liability limits. These two illustrations emphasize why a periodic review of the policyholders' needs is important so that their insurance programs meet their present requirements. Many agents will find similar cases.

Some agents will say "Oh, well! I am only writing a small policy for Jones. Let someone else who is writing a large share of his business do it." From the present income standpoint, they may be right, but from the standpoint of properly servicing the policyholders that they now have, they are not rendering all the service it is possible to give. Remember, if the policyholder

is properly serviced, new business may be secured. New business means added income. None of us are allergic to increased incomes.

Income gained in this way gives the agent a feeling of satisfaction because he has performed his work well. On the other side of the picture, a policyholder feels that his interests are being properly looked after. The agent gains stature in the eyes of his clients. If the agent has done a good job, even though he has not been able to gain any new business, he is likely to receive some future business from the firm as well as to be recommended to other firms. Sometimes the latter is even more valuable than the business that might be obtained from the original firm surveyed.

Principles of Sound Insurance Selling

Need for Protection

The first principle of insurance selling is to determine where the need for protection exists. Most people recognize the existence of such perils as fire, windstorm, etc. but less consideration is given to the financial consequences (indirect losses) resulting from the destruction of property or life by these perils. Some of these financial consequences may be increased operating costs, terminated leases, or destroyed records. Any or all of these could cause financial pressure. Protection against them is as essential as protection against the direct loss of a building by fire. It is the duty of the agent to determine which contingencies would cause the greatest financial loss to the firm and try to cover these first.

Required coverages. Agents should start with those coverages that are required by law or contract. Some of these are: (1) workmen's compensation; (2) bid bonds on government or private contracts; (3) pension plans, and group life and health insurance required in most union contracts; and (4) the quasi-compulsory coverage made necessary because of the Financial Responsibility Laws.

There are many other coverages which are necessary to the firm because of the financial loss that might be suffered through the destruction of life or property. One of these coverages is life insurance on key employees. The amount of this insurance should be large enough to provide for any loss suffered because of interruption in business affairs because of death. In many cases, someone must be trained for the position or hired from outside at perhaps a higher salary. In either case, a transition period is necessary. In the case of a partnership, a sufficient amount of life insurance should be carried on the respective partners to permit those remaining to purchase the interest held by the deceased. Otherwise the business is forced into liquidation with a sacrifice of assets because of forced sale or the remaining partners have to accept the heirs of the deceased as partners.

Another essential coverage is a firm's responsibility for third-party liability. Some of the questions that require answers in determining the extent of coverage are:

1. To what extent are the firm's operations subject to large losses because of bodily injury or property damage?
2. To what extent can the firm afford to suffer large losses?
3. What is the prevailing trend of juries in awarding large judgments?
4. What additional coverage is necessary to cover liabilities in excess of statutory limits?

Some examples of the importance of these answers can be found in the following judgments awarded by the courts. An Ohio cab driver was awarded $150,000 when his wife lost her sanity because of an injury suffered in an auto accident. In another case, a judgment for $100,000 was

awarded when an "I" beam protruding from a steel company truck swept some radar parts from a passing railroad flat car. Most agents have read about the $750,000 damages awarded to a nine-year-old boy for injuries received during a gas explosion in Roselle, Illinois. The two utility companies settled out of court for $600,000 after the decision was upheld by a judge of the Chicago Superior Court. Another example would be the Lawrence M. Rohde Case, settled in Milwaukee, Wisconsin, in which the Olsen Transportation Company of Green Bay, Wisconsin had to pay an award of $117,000. The trucking company carried individual limits of $100,000.

Determination of adequate coverage. The adequacy of the present insurance program can best be determined by an "insurance survey" or "risk analysis" by brokers or agents. A complete insurance survey should:

1. Determine the property, perils, and losses to which the insured is exposed;
2. Determine the best and least costly way to arrange the insurance necessary to protect against these exposures;
3. Study loss prevention in order to utilize all avenues for rate reduction;
4. Analyze the present insurance and make the necessary changes to adjust the insurance to the recommended program; and
5. Provide a method of keeping the insurance program up-to-date.

Extent of Possible Losses

The second principle is to determine the extent of possible losses and cover the major uncertain losses only. This can be done by classifying the coverage of the possible losses as essential, desirable or available. The first should definitely be covered. The second may be covered if the premium dollars are available. The third may be covered if the the client so wishes. Many people are willing to swap dollars for dollars in the sense that they buy coverages, such as emergency road service, where only small losses are involved. Another example is one in which a wealthy man, who could easily pay normal hospitalization expenses without any financial burden, buys a hospitalization policy only. He should buy a major medical policy with a large deductible to protect himself against catastrophic losses. Most people can visualize small losses; it is sometimes hard to visualize the large ones that need to be covered with insurance. It is the agent's responsibility to try to help his clients see their insurance needs in the proper perspective.

When large catastrophic losses are covered, the insured must be reconciled to the fact that he may pay premiums for years without any recovery. Actually the insured should be made to understand that the substitution of a known loss (the premium) for a large unknown loss (the potential loss that he has) makes it possible for him to forecast his operating costs for continued business operations.

In suggesting methods for covering an insured's potential losses, an agent should study the possibility of a firm being a self-insurer or of making use of large deductibles. Where a firm is able to suffer a loss without harm to the financial status of the business itself, such plans are feasible. For example, the Standard Oil Company of Indiana has carried a $500,000 deductible fire insurance policy on its refineries. Each firm must determine the amount of risk that it is financially expedient to bear. The amount may also vary from year to year depending on the financial commitments that the insured may have made.

Analysis of the Probability of Loss

The third principle is to analyze the probability of loss. The probability of loss ranges from zero (no chance of loss) to unity (certainty of loss in a given period).

It is usually expressed in a fraction. If a certain area of land could be expected to flood every other year, the fraction would be one to two or 50 per cent. High probability of loss makes insurance premiums very expensive, especially after adding the necessary loading for operating expenses of the insurer. The insurer collects from each insured his proportionate share of the losses for the group plus the expenses of operating the insurance company.

The upper limit beyond which the buyer is unwilling to buy insurance is impossible to determine with exactness. The lower limit would be the point where the buyer considers the likelihood of loss to be so slight that he is willing to assume the burden himself. The extent of loss to be suffered will cause this lower limit to fluctuate, for example, a potential claim for $100,000 would outweigh a small probability of loss. The relative amount and the probability of loss must both be taken into account in determining the extent of insurance protection needed.

Reduction of Insurance Costs

The fourth principle is to determine methods by which insurance costs may be reduced. Some methods now being used are:

1. Deductible insurance which has been developed to eliminate coverage on small losses. Small losses tend to occur fairly frequently. The use of a high deductible is less related to loss frequency. It has been designed to give the insured the opportunity to bear any loss up to the limit he feels that he is able to handle. The savings in premium between a $25 deductible and a $50 deductible collision coverage is almost equivalent to the value of the additional protection offered the insured. Thus the larger deductible policy tends to lower insurance costs.

2. Coinsurance which offers the insured a reduced rate per unit of protection in return for his acceptance of a volume of insurance based on a stated percentage of the property value. If the insured does not carry the required amount of insurance, he becomes a coinsurer with the insurance company on all losses. If he does carry the required amount, he has one hundred per cent protection on all losses up to the face of the policy.

3. Contracts with terms of more than one year, such as three to five year contracts, e.g., the premium on a three-year fire policy costs from 2.5 to 2.6 times the premium of a one-year policy.

4. Compliance with certain construction and operation standards in building codes and underwriting standards. Examples of this are the installation of sprinkler systems, fire doors, fireproof containers, fire alarm systems and watchmen. The insured should be informed of ways and means of reducing premium costs through loss prevention methods. Suggestions which would help the client qualify for a lower rating classification should be made also.

5. Self-insurance plan. This is possible where an adequate fund can be administered in a proper manner separate and distinct from the rest of the business. Other fundamental self-insurance principles should be considered if this first principle can be met. They are: (1) the insured property should include a large number of homogeneous exposures which are exposed to the same hazard or hazards, (2) each individual potential loss should be relatively small in value as compared with the whole, and (3) the exposure units should be geographically dispersed as well as have a definite loss pattern.

The experience of individual firms considering self-insurance should have been favorable prior to the induction of the plan. Self-insurance should not be attempted by a firm in financial difficulty. Management must be willing to perform all of the services of an insurer or hire

someone to do so. These services include loss prevention, claim services, maintenance of adequate reserves, etc. All of this is necessary for a self-insurance plan to be successful. An agent should constructively advise the management of any given firm as to the advantages, requirements, and pitfalls of a self-insurance program for that firm.

6. Modified self-insurance or stop-loss insurance plan. Under this plan an insured agrees to suffer his own losses up to an amount equal to a certain percentage of his customary insurance coverage. A reinsurer agrees to assume all losses over and above the percentage or amount assumed by the insured. This device is especially appropriate for firms showing a favorable loss experience, and possessing sufficient liquid assets to withstand their share of the loss.

Contents of the Policy

The agent should endeavor to acquaint the insured with his insurance contracts. Although courts tend to construe passages, the meaning of which is not clear, in favor of the insured, his ignorance will not alter the coverage of the contract.

Insurance contracts usually contain five major divisions. They are the declarations, insuring agreements, exclusions, conditions and endorsements.

Declarations. Declarations include such things as the insured's name, location and description of the property, and any other specific facts required for underwriting, as well as the amount of insurance requested, the premium for each coverage and the term of the contract. The insured is held responsible for all material facts in these declarations. A material fact is anything which would cause the insurer to refuse to issue the policy or to have it issued at an increased rate. An example of this would be a building which was insured as a warehouse for metal goods but was in fact used to store petroleum products of a highly inflammable nature. Such a misstatement of fact would relieve the insurer from liability. In addition to this, the insured must reveal pertinent information which might influence the underwriter's judgment, even though no inquiry was made.

Insuring agreements. Insuring agreements state the perils insured against and the obligations that the insurer will assume. The obligations of the insurer include such things as inspection of the premises, defense of the insured when legal action occurs, payment of any immediate medical expenses and the investigation of claims. In the case of boiler insurance, inspection costs account for a major portion of the premium.

Exclusions. Exclusions are divided into five categories. The first of these are objects subject to excessive hazards. One example of such hazards is the use of a house as a dry cleaning establishment when it is insured as a private residence. Another example of such a hazard would be a loss by theft under the residence and outside theft policy, which was committed by a relative of the insured who was residing on the premises at the time of the theft.

The second category is catastrophic losses. This refers to the unusual losses such as war, including invasion, civil war, insurrection, rebellion and revolution.

The third category of exclusions eliminates coverage on property normally covered under another insurance policy. For example, the mercantile open stock burglary policy does not apply to losses normally covered under one of the fidelity policies available, such as acts that are performed by an employee.

The fourth type of exclusion is for losses wholly or partially under the control of the insured. These include losses caused by or at the direction of the insured, such as the insured's automobile running into

and damaging his own house. It it contrary to public policy to allow the insured to recover for his felonious self-destruction of his own property.

The last of these exclusions covers loss to property due to normal wear and tear. Insurance is designed to protect the insured from unexpected losses and not from the normal expected loss from use and obsolescence. Depreciation is a normal business expense and should be recovered from revenues over the life of the asset.

Conditions. The fourth major division of the policy states the conditions affecting the contract. They include the definition of the terms used in the contract and a statement of the rights and obligations of all parties. For example, in the standard fire contract, fire losses must result from an unfriendly (hostile) fire which is defined as a fire outside its proper receptacle. Therefore, smoke damage caused by faulty operation of a fireplace is not recoverable. It is important for the agent to interpret to the insured the technical meaning of the various terms used in the contracts. This enables the insured to ascertain what coverages he has.

The section containing the conditions sets forth various limitations affecting the recovery rights of the insured. These limitations are:

1. The individual limits are stated as well as the total limits under the policy;
2. Loss payments are restricted to the actual cash value of the property destroyed;
3. Coinsurance requirements, other insurance on the property, etc. must be adhered to;
4. Abandonment of the property to the insurer is prohibited;
5. The insurer has the right to repair, replace or offer a cash settlement for the loss; and
6. The company's position in salvage operations is specified.

Other conditions set forth in the contract are the duties of the insured in case of loss, the requirement of notice and proof of loss, the assistance that the insured must give, the subrogation of the insured's rights, the conditions as to cancellation or suspension of coverage, the inspection of property, the assignment of the contract, insolvency or bankruptcy of the insured, rights of the agent to change the terms, and the affect on the policy of declarations made by the policyholder.

Endorsements. The final division of an insurance contract contains the endorsements or riders. These endorsements or riders extend or restrict the coverage of the basic policy, modify the contract as to errors, assignments or interests, transfer coverage from one object or location to another, and state any changes in the amount of the coverage carried. The endorsement takes precedence over the section of the basic contract that it modifies and lends flexibility to the insurance contract so it meets the needs of various insureds.

Methods of Risk-Bearing Open to the Insured

Insurance is only one method of risk-bearing. Other methods that may be employed are the control of risks through educational means, the transfer of the risk to specialists, the assumption of the risk by the insured, and the combination of groups or individuals formed to offset uncertainty of loss by exchanging a small known loss for a large uncertain one. This is one method of covering hard-to-place business.

The most desirable solution to risk-bearing is the elimination of risk in its entirety. This is impossible unless you dispose of the object exposed to the risk. The next best solution is the preventing of losses through research which reduces

the causes of the loss. An example of this would be the proper placement of guards on machines to prevent injury to workers. Other examples would be the use of nonskid surfaces in such places as stairways and halls, and the adoption of certain safety practices in the handling of combustible substances. The introduction of these safety measures will lessen the severity and frequency of losses. It will pay dividends in terms of less man-hours lost, increased production and lower insurance and other risk-bearing costs.

The agent should advocate the transfer of risks to specialists if it is not already being done. The use of hedging practices by grain dealers, subcontracting by primary contractors, and the use of bid bonds in large contracts are examples of this practice. It tends to relieve management of some of the risk which normally places extra burdens on the finances of the firm. Under insurance, the risk is not transferred entirely as each insured bears a known portion of it, namely his insurance premium.

If losses are limited and predictable, management can safely assume the risk by the creation of a reserve fund which is subject to the same rules as self-insurance. A small company would be ill-advised to cover the risk of liability judgments in this manner. The assumption of risk without a fund, unless the risk is very small, would be likely to put undue pressure upon the liquidity of the firm.

The combination of risks may take several forms. One might be a small group of individuals who are faced with a given risk which they are unable to place or the cost of which, if placed, would be prohibitive. It is possible for this group to share all or a portion of the loss. The group may try to cover excessive losses through insurance. Another form might be the incorporation of a number of individual businesses for the purpose of increasing the financial ability to withstand loss, as well to limit the loss of any one firm.

Summary

Agents have an important place in the building of a sound insurance program for their clients. If the agent wishes the policyholder to respect him as an insurance advisor, he must demonstrate his ability to analyze the policyholder's needs and to recommend the ways and means of meeting these needs. He must emphasize the wise use of each premium dollar by reviewing each client's individual needs periodically and applying the principles of sound insurance selling to the problems of each. As new needs arise, they should be fitted into the overall program. Care should be exercised so that coverages do not overlap and thereby waste the client's premium dollar. Risks which entail the greatest financial losses should be covered at all times.

The client must be aware that the service which the agent performs is beneficial to himself and not just a monetary gain for the agent. He must know that the coverages recommended are, in the agent's opinion, those which will most adequately and economically cover the risks which the policyholder is exposed to.

Agents who try to follow the suggestions made above will help to increase the stature of the insurance agent in the minds of the public and thereby aid in raising insurance from a business to a profession.

THE NEGRO INSURANCE MARKET IN BALTIMORE, 1957

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A considerable amount of attention has been focused upon the Negro market during recent years. Studies of the Negro market have treated buying preferences of consumers in regard to a number of products and services. Several articles and theses have been written about the volume of life insurance written by companies with colored management. A study of the literature in the field of life insurance indicates that little attention has been paid to the Negro life insurance market.

During the spring of 1957, 1297 Negro heads of households, selected at random, were interviewed in order that a study of the Negro insurance market in Baltimore might be made. A table of random numbers was used for the purpose of selecting both the census tracts and the blocks in the census tracts in which interviews were made. The head of the household in every other house in the blocks which were selected was interviewed by a member of the senior research class in Economics at Morgan State College. It is the writer's opinion that the sample is representative of the universe from which it was taken.

The median income of the individuals who were included in the sample was approximately $3,000. Some 635 heads of households were included in the $1,000 through the $2,999 income group; another 557 heads of households were included in the $3,000 through $5,999 income group; the $6,000 and over group included 62 heads of households. The other 43 heads of households did not indicate the income group in which they belonged. The median income of $3,000 for a Negro head of household in Baltimore is in line with recent estimates that have appeared in other studies.

Approximately 93 per cent of the 1297 heads of households who were interviewed were young enough to purchase additional life insurance. Fifty-six per cent were in the 20 through 39 age group; thirty-seven per cent were in the 40 through 59 age group; the other 7 per cent were in the 60 and over group.

Ninety-three per cent of the heads of households who were interviewed said that they had insurance in force on their lives. Only 86 informants out of 1297 indicated that they had no life insurance. Another 65 individuals said that they had life insurance but that they did not remember either the size of their policies or the names of the companies that insured them. The insurance in force which is presented in Table 1 is the aggregate amount of insurance reported by the 1164 informants, 88 per cent of the total, who remembered both the size of their policies and the names of the insurers.

The 1146 heads of households had $1,841,049 worth of insurance on their lives, which includes $381,500 worth of National Service Life Insurance and $13,580 worth of insurance carried with companies whose names could not be identified. The $1,445,969 worth of insur-

TABLE 1

INSURANCE IN FORCE* ON 1,146 NEGRO LIVES IN BALTIMORE, 1957

Type of Insurance	*Total*	*Insurance in Force* *Negro Companies*	*White Companies*
Ordinary	$ 867,540	$104,600	$ 762,940
Industrial	464,049	123,053	340,996
Group	114,380	6,730	107,650
TOTAL	$1,445,969	$234,383	$1,211,586
PERCENT	100%	16%	84%

* Does not include $381,500 worth of National Service Life Insurance and $13,580 worth of insurance carried with companies whose names could not be identified.

ance that they carried with private insurance companies, see Table 1, was divided as follows: ordinary, $867,540; industrial, $464,049; group, $114,380. The average amount of life insurance possessed by the insured heads of households was $1,607.

A relatively large percentage of the insurance in force in the Negro market is written on the industrial plan. Thirty-two per cent of the insurance in force on the lives of the individuals interviewed was industrial. Less than 9 per cent of the insurance in force in the United States in 1957 would be classified as industrial.[1]

How was the Negro market shared by companies with Negro management and companies with white management? Five companies with Negro management had $234,383 worth of insurance in force,[2] while 52 companies with white management had $1,211,586 worth of insurance in force. Thus, companies with white management had 84 per cent of the market.

Companies with Negro management had a larger percentage of the industrial business than they did of either of the other major classifications of types of life insurance. The $123,053 worth of industrial insurance represented 27 per cent of the total industrial insurance carried by the group; the $104,600 worth of ordinary insurance represented 12 per cent of the total ordinary insurance in force, excluding National Service Life Insurance; the $6,730 worth of group insurance carried with Negro companies represented only 6 per cent of the group insurance in force on the lives of the informants.

Did the individual companies that gained the largest share of the Negro market have white or Negro management? One company with white management had more insurance in force in the Negro market than the total for all the companies with Negro management. One other company with white management had more insurance in force on the lives of the informants than any company with Negro management. Two companies with white management had a larger share of the Negro market than any company with Negro management.

Are agents contacting members of the Negro market for the purpose of selling life insurance? Agents of insurance companies had contacted 51 per cent of the individuals in the 20 through 39 age group, 57 per cent of those in the 40 through 59 age group, and 64 per cent of those in the 60 and over age group during the previous twelve months in an effort to sell life insurance. Fifty per cent of the informants who earned over $3,000 had been contacted, while only 43 per cent of those who earned less than $3,000 had been approached by an agent during the previous year. Only 46 per cent had been contacted by agents during the previous year.

Were the contacts in the Negro market made primarily by representatives of companies with Negro or white management? Representatives of 27 companies with white management made 67 per cent of the contacts, while representatives of four Negro companies made 33 per cent

[1] Institute of Life Insurance: *Life Insurance Fact Book*, 1959, p. 10.

[2] While only four companies with Negro management operate in Maryland, one informant reported that he had an insurance policy with a Negro company that does not operate in the State.

of the contacts. The largest number of contacts, 18 per cent of the total, were made by representatives of a company with Negro management; but two-thirds of all contacts were made by agents of white companies.

Did the members of the Negro market consider their life insurance adequate? Approximately 21 per cent stated that they did not have enough life insurance. Seventy-eight per cent considered their life insurance coverage adequate. The other 12 per cent stated that they did not know whether they had adequate coverage.

A larger percentage of the individuals who were in the highest income group considered their life insurance coverage inadequate than the percentage in the lower income groups. Over 27 per cent of the informants whose earnings were $6,000 and over considered their insurance coverage inadequate. The percentages of informants in the $3,000 to $5,999 group and the $1,000 to $2,999 group who considered their coverage inadequate were 20 and 21 respectively.

The percentage of informants who considered their protection inadequate also varied by age groups. Only 19 per cent of the individuals in the 40 through 59 age group considered their protection inadequate. The percentage of informants considering their protection inadequate rose to 22 per cent for the 20 through 39 age group and 24 per cent for the 60 and over age group. A larger percentage of informants who were 60 and over considered their insurance inadequate than the percentage of either of the younger age groups.

The majority of the informants, 56 per cent, thought the policies sold by Negro companies cost approximately the same as policies sold by white companies. One-fifth of the individuals said that they did not know whether policies sold by Negro companies cost more than, less than, or the same as policies sold by white companies. The cost of policies sold by Negro companies was considered less than that of white companies by 13 per cent of the informants, and the percentage was constant for all income groups.

The percentage of informants who thought that policies sold by Negro companies cost more than those sold by white companies increased from 9 for the $1,000 to $2,999 income group to 11 for the $3,000 to $5,999 group and to 16 for the $6,000 and over income group. The percentage of individuals who associated higher than average cost with Negro companies increased as their incomes increased.

The majority of the informants, 61 per cent, considered Negro and white insurance companies equally sound financially. Only 3 per cent of the informants considered Negro insurance companies financially more sound than white insurance companies, while 19 per cent considered white insurance companies more sound than Negro insurance companies. The other 16 per cent said that they did not know which companies were financially more sound. The replies tended to vary more when considered by income groups than when considered by age groups.

A larger percentage of the informants in the higher income group considered Negro companies financially less sound than the informants in the lower income group. Negro companies were considered less sound by 27 per cent of the individuals who earned over $6,000, while only 19 per cent of those who earned less than $6,000 shared this opinion. The per cent who considered Negro companies more sound increased from 3 for the lowest income group to 4 for the middle income group and 5 for the upper income group. The per cent who considered Negro companies equally as sound as white companies declined as incomes increased.

A larger percentage of the younger in-

formants considered Negro companies equally as sound as the white companies than did older informants. Negro companies were considered equally as sound as white companies by 62 per cent of the individuals in the 20 through 39 age group and 57 per cent of the individuals in the 40 through 59 age group. The percentage who considered Negro companies less sound was 18 for the younger age group and 22 for the older age group. A larger percentage of the older informants considered Negro companies financially less sound than the younger informants.

Only 49 per cent of the informants remembered having seen or heard any insurance advertisements during the last year. Approximately 1 per cent either failed to reply or did not know whether they had seen or heard any insurance advertisements. The 50 per cent who had not seen or heard insurance advertisements varied directly with age groups. It increased from 47 per cent for the 20 through 39 age group; to 54 per cent for the 40 through 59 age group; and 60 per cent for the 60 and over group. The percentage who had not seen or heard insurance advertisements was 53 per cent for the $1,000 through $2,999 income group; 47 per cent for the $3,000 through $5,999 income group; and 35 per cent for the $6,000 and over group. The percentage who did not remember having seen or heard insurance advertisements last year decreased as incomes increased.

Approximately one-sixth of the informants stated that they planned to buy insurance during the coming year. Although 17 per cent planned to buy insurance during the coming year, the others had made no plans for purchasing insurance in the immediate future. Plans to buy insurance during the next year varied considerably by age groups. While 23 per cent of the informants in the 20 through 39 age group planned to buy insurance, only 12 per cent of the informants in the 40 through 59 age group contemplated purchasing it. The percentage of individuals planning to purchase insurance during the coming year varied inversely with age.

Plans to purchase insurance during the next year also varied considerably from one income group to another. Insurance purchases were planned by 19 per cent of the individuals in the $1,000 through $2,999 income group; 16 per cent of the $3,000 through $5,999 group; and 85 per cent of those whose incomes exceeded $6,000. A much larger percentage of the individuals who were in the highest income group planned to buy insurance than the percentage of individuals in either of the lower income groups.

The informants were requested to indicate the type of insurance that they planned to buy in the future, whether they planned to make a purchase during the next year or not. Approximately 31 per cent indicated the type of insurance they planned to purchase. Based upon the 399 informants who indicated the type of insurance they planned to buy, 53 per cent planned to purchase ordinary; 24 per cent planned to purchase industrial; and 23 per cent planned to purchase group.

Plans to purchase industrial insurance increased directly with age. Industrial purchases were planned by 23 per cent of the 20 through 39 age group, 25 per cent of the 40 through 59 age group, and 38 per cent of the 60 and over group. Group insurance purchases were anticipated by 22 per cent of the younger group, 26 per cent of the middle age group, and 12 per cent of the older age group. A larger percentage of the younger individuals planned to purchase ordinary than the older individuals.

There appears to be no correlation between informants' incomes and the type of insurance that they planned to buy. Group insurance purchases were contemplated by 23 per cent of the individuals

who earned less than $6,000, and by 19 per cent of those who earned more than that amount. Ordinary insurance purchases were planned by 48 per cent of the $1,000 through $2,999 income group; 59 per cent of the $3,000 through $5,999 income group; and 44 per cent of the $6,000 and over group. Industrial purchases were planned by 29 per cent of the $1,000 through $2,999 group; 18 per cent of the $3,000 through $5,999 group; and 37 per cent of the $6,000 and over group. The relatively small percentage of replies to this question by the $6,000 and over group may be responsible for the surprising result that the largest per cent of individuals planning to buy industrial insurance and the smallest per cent planning to buy ordinary insurance were in the highest income group.

DUPLICATION OF GOVERNMENT INSURANCE IN COMMERCIAL BANKS

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Within a year it is predicted that outstanding government—guaranteed or insured loans will reach a total in excess of $82,000,000,000. A myriad of federal departments and agencies offers this insurance to private lenders on loans that have been extended to borrowers in such areas as housing, commerce, foreign trade, and agriculture. Many of these lenders are commercial banks. Throughout the 1950's they have, for example, held approximately 30 per cent of their mortgages under the Federal Housing Administration insurance program.

When commercial banks participate in loan insurance programs, a special situation develops which results in the insurance of both sides of the bank's balance sheet, an unnecessary duplication of insurance and insurance premiums. For purposes of illustration the loan procedures of commercial banks may be briefly reviewed. A distinguishing feature of a commercial bank is that it is chartered to create demand deposits subject to check, provided that legal reserve requirements are met. The typical commercial bank loan is granted to the customer in the form of a demand deposit. The commercial banking system thus monetizes the debts of individuals, businesses, and governments. The greater part of the demand deposits shown on the liability side of the bank's balance sheet is in practice loan-derivative. A new customer granted a loan receives both a new account and a demand deposit in it. Former customers with established accounts receive additional deposits in these accounts.

In commercial banks that are members of the Federal Deposit Insurance Corporation—and this includes most commercial banks—deposits in one name in one bank are insured to the amount of $10,000. When commercial bank customers write checks to use the proceeds of their loans, these amounts, after the completion of the clearing process, come to rest in other accounts which in most cases are also government-insured. It is worth noting, in addition, that in practice demand deposits are often insured 100 per cent regardless of size. This comes about when the merger method of handling distressed banks is chosen. The FDIC is authorized to arrange mergers between failing and strong banks in cases where this appears the most economical course for the FDIC in the long run. In facilitating such mergers, the FDIC either makes loans to the failing institution or purchases its substandard assets so that the stronger participant in the merger is not weakened through the assumption of new assets. Deposits, on the other hand, are transferred to the merged institution intact in these cases. Thus, in effect there is 100 per cent insurance coverage for the depositor. Since the war the FDIC has chosen the merger method often and with increasing frequency.

Turning now to the asset side of the

commercial bank's balance sheet, one finds a listing of insured and guaranteed loans. It becomes obvious that in the case of these loans the government is insuring both sides of the bank's balance sheet through insuring the loan as well as the derivative deposit. The question arises as to whether this is necessary, especially since it is the rule, with very minor exceptions, for these government agencies and departments to charge premiums which represent an addition to the costs of bank operation. It appears that banks may be over-insured.

The solution to this problem of government over-insurance does not appear to lie in the discontinuance of loan insurance programs, although this means might first come to mind on the grounds that deposit insurance preceded the inauguration of all of these loan insurance programs. Upon examination, however, loan insurance actually offers more to both the banker and the community. It helps the banker face two major problems—those of solvency and liquidity. To the extent that his assets are government-insured, they are as satisfactory as either government bonds or cash. Because his assets are sound, they may be liquefied at the Federal Reserve as a last resort in emergencies. The Banking Act of 1935 provides institutional liquidity to member banks with satisfactory assets when it is necessary to convert these assets to cash and when this cannot be reasonably done in the open market. Under a repurchase agreement with the member bank needing liquidity, the Federal Reserve is committed to acquire temporarily intrinsically sound assets. Therefore solvency now is synonymous with liquidity for member banks. Loan insurance makes a major contribution to bank solvency.

Viewed as selective or qualitative credit controls, loan insurance programs also play a vital role in monetary policy. The application of selective credit controls makes it possible for monetary authorities either to restrict or expand credit in one or more sensitive sectors of the economy without necessarily imposing an equivalent degree of credit restraint or ease in other sectors. When used effectively in times of inflation, selective credit controls lower the rate of interest necessary to restrict aggregate credit to chosen levels. Many economists are convinced that a further extension of selective credit controls is inevitable to complement overall credit measures and to check to a greater degree the amplitude of economic fluctuations. In this realm of qualitative credit control the potential of loan insurance is far greater than anything realized as yet. At the present time, central banking powers are not effectively coordinated and remain diffused among the Federal Reserve and a number of government departments and agencies. In the future it is expected that steps will be taken to minimize this diffusion.

Since the earliest loan insurance was in the housing area and it is there that the most progress has been made, this insurance program serves as an illustration of several other advantages attainable through the loan insurance device. One of these is that loan insurance both widens and standardizes the particular credit market involved. The market for FHA and VA insured and guaranteed residential mortgage loans has become nationwide in character and scope, while only the conventional mortgage is an impediment to the coast-to-coast flow of housing funds.

When the government insures a loan, it sets the terms of the loan. In the case of mortgage loans, this has meant not only greater interest rate uniformity but the standardization of appraisal methods and the introduction of uniform mortgage documents. Conventional mortgages, on the other hand, are created under diverse state laws and are, for the most part,

suitable for local marketability only. In addition, since the lender bears all of the risk under conventional mortgage arrangements, he sets the interest rate at a level to include compensation for risk bearing. Considerable variation in interest rates is thus introduced.

It is interesting to note that in studying the regional pattern of interest rates in general, Saulnier and others found commercial bank business loan rates to be no more uniform than in the period 1920-24, while the emergence of a more uniform pattern of home mortgage rates was clearly indicated. They say: "This would suggest that the standardizing trend has made greater progress in the mortgage market than elsewhere and is therefore perhaps largely attributable to the federal programs of loan insurance." [1]

Federal housing credit programs also have been aimed at improving the terms of borrowing other than interest rates. The short maturity loan has been discouraged through the substitution of a more liberal first mortgage. Lending practices have been improved by the introduction of debt retirement through prescheduled amortization.

On July 1, 1959 the Federal Housing Administration put into effect a new national minimum property standard aimed at allowing builders and buyers more flexibility in planning homes. This is the first time that there has been a national minimum standard. In establishing this new standard, the FHA has, among other things, attempted to make uniformly applicable a number of regulations which in the past have been applied differently in 28 regions. In the new code the quality of housing should be raised through the provision of such items as increased room sizes, flexible bedroom sizes, the establishment of minimum dimensions for each room, and new emphasis upon space. Requirements of lot size have been eliminated, and FHA approval is now based upon lot character and marketability. Builders are more free with regard to the way in which they place a house on its lot.

Finally, the FHA and VA insurance and guaranty programs have aided banks in securing better earnings. Although commercial banks take part in the mortgage market in varying degrees, as a group they engage in all major classes of real estate finance. This includes construction lending, interim financing to support the nationwide distribution of federally-underwritten mortgages, permanent investment in mortgages, and the origin and servicing of mortgages for other lenders.

Recently the American Bankers Association published a pension fund study [2] underwritten by thirteen banks on a voluntary basis, initiated by the Association's Committee on Real Estate Mortgages, and conducted by Mr. John J. Redfield. The study points out that banks—often the same banks—are both custodians of savings and trust and pension funds, and are also originators of mortagages. Attention is directed to possible new opportunities for pension fund investment in federally-insured and guaranteed mortgage loans. Stress is placed upon the fact that under almost all pension trust instruments government mortgages are permissible investments. Since pension trustees can actuarially predict future cash needs, it is shown that lack of market stability of mortgages relative to bonds is not a drawback provided amortization and maturities are properly scheduled. However, the experience of the Fifties indicates good marketability for both FHA and VA insured loans.

This brief examination of the contri-

[1] Saulnier, Halcrow, and Jacoby, *Federal Lending and Loan Insurance*, National Bureau of Economic Research, 1958, p. 351.

[2] American Bankers Association, *Pension Fund Investment in Federally Insured and Guaranteed Loans Through Correspondent Banks*, New York, 1959.

butions of loan insurance indicates something of the importance attached to the introduction of this concept to the American economy. Rather than sacrifice these gains, it seems that the problem of the duplication of insurance in the commercial banking system should be tackled through some type of plan involving a formula for the allowance of credit for loan insurance premiums already paid in the determination of deposit insurance premiums to be paid. In this manner, at least, the duplication of insurance premiums could be eliminated. This suggestion is based on the assumption that for psychological reasons deposit insurance should not at present be terminated. Thus that alternative is eliminated for the foreseeable future.

RESEARCH AND PUBLICATIONS

Insurance Research Inventory

1950 - 1959

The following inventory of insurance research completed during the period, 1950-1959, is incomplete in that: (1) it embraces only work done by those members of AAUTI who responded to the Research Committee's questionnaire, and (2) complete bibliographical data was not given for all publications listed.

This bibliography was compiled under the direction of John F. Adams, Temple University, Chairman of the AAUTI Research Committee, by Marie-Louise Woodard.

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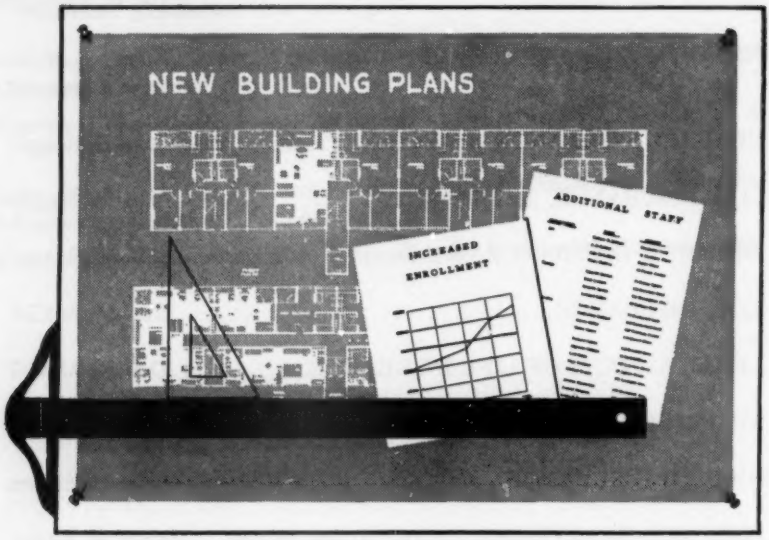

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